IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF SACRAMENTO

HONORABLE JUDY HOLZER HERSHER, JUDGE, DEPARTMENT 45

---oOo---

JOAN BOICE, by and through her Successor-in-Interest, ERIC BOICE, and ERIC BOICE, NANCEE BOICE, and MARK BOICE, individually,	)	
Plaintiffs,	)	Case No.
vs.	)	34-2009-00063714
EMERITUS CORPORATION dba EMERITUS AT EMERALD HILLS,	)	
Defendant.	)	

---oOo---

REPORTERS' DAILY TRANSCRIPT OF PROCEEDINGS

---oOo---

THURSDAY, FEBRUARY 28, 2013

---oOo---

DIANNE COUGHLIN, CSR No. 10418

BURGUNDY B. HENRIKSON, CSR No. 11373

APPEARANCES:

For the Plaintiffs:

CLEMENT & ASSOCIATES
LESLEY ANN CLEMENT, Attorney at Law
SEAN LAIRD, Attorney at Law
VALERIE DAWSON, Attorney at Law
2209 J Street
Sacramento, California 95814
(916) 444-9323

- AND -

DOLLAR, BURNS & BECKER
ASHLEY BAIRD, Attorney at Law
1100 Main Street, Number 2600
Kansas City, Missouri 64105
(816) 876-2600

For the Defendant:

LEWIS, BRISBOIS, BISGAARD & SMITH, LLP
BRYAN R. REID, Attorney at Law
RIMA BADAWIYA, Attorney at Law
650 E. Hospitality Lane, Suite 600
San Bernardino, California 92408
By: BRYAN R. REID, Attorney at Law

- AND -

LEWIS, BRISBOIS, BISGAARD & SMITH, LLP
KIM M. WELLS, Attorney at Law
2850 Gateway Oaks Drive, Suite 450
Sacramento, California 95833
(916) 564-5400

---oOo---

I N D E X

---oOo---

PAGE

E X H I B I T S

[None marked.]

---oOo---

THURSDAY, FEBRUARY 28, 2013

MORNING SESSION

--oOo--

The matter of JOAN BOICE, by and through her Successor-in-Interest, ERIC BOICE, and ERIC BOICE, NANCEE BOICE, and MARK BOICE, individually, Plaintiffs, vs. EMERITUS CORPORATION dba EMERITUS AT EMERALD HILLS, Defendants, Case No. 34-2009-00063714, came on regularly this day before Honorable JUDY HOLZER HERSHER, Judge of the Superior Court of the State of California, for the County of Sacramento, Department 45.

The Plaintiffs, JOAN BOICE, by and through her Successor-in-Interest, ERIC BOICE, and ERIC BOICE, NANCEE BOICE, and MARK BOICE, individually, were represented by LESLEY A. CLEMENT, ASHLEY BAIRD, SEAN LAIRD, and VALERIE DAWSON (not present), Attorneys at Law.

The Plaintiffs ERIC BOICE, NANCEE BOICE, and MARK BOICE were present.

The Defendant, EMERITUS CORPORATION dba EMERITUS AT EMERALD HILLS, was represented by BRYAN R. REID, RIMA BADAWIYA, and KIM M. WELLS, Attorneys at Law.

Also present on behalf of the Defendant, EMERITUS CORPORATION dba EMERITUS AT EMERALD HILLS, was JANET E. McKINNON, Vice Present of Legal Affairs; LISA HULSE, Vice President Quality & Risk Management; and HOLLY FORD, Trial Consultant.

- - -

- - -

The following proceedings were had in the presence of the jury:

THE COURT ATTENDANT: All rise. Department 45 of the Sacramento Superior Court is now in session, the Honorable Judge Judy Hersher presiding.

You may be seated.

THE COURT: Good morning, ladies and gentlemen.

THE JURY PANEL: Good morning, Your Honor.

THE COURT: Terrance will have left on each of your chairs the revised couple of pages to insert in your binder. I'll give you a minute to do that.

All right.

You may recall that the order of the closing arguments is going to be Ms. Clement first, because she has the burden of proof with respect to her case. When she's done, Mr. Reid is going to speak to you with respect to his argument. When he's done, it goes back to Ms. Clement for what's called "rebuttal," and she has the last word, so to speak, because the burden of proof with respect to all of the elements of the case remain with the plaintiffs.

We are going to be taking our breaks depending on sort of the natural timing of how things flow this morning. If we tend to go a little bit beyond our standard time, and somebody needs to take a break for some reason, just wave at me and we'll take a break, okay?

Ms. Clement, do you wish to make a closing argument?

MS. CLEMENT: Yes, I do, Your Honor.

THE COURT: Please proceed.

MS. CLEMENT: Thank you.

CLOSING ARGUMENT

MS. CLEMENT: "We are called to be people of conviction, not conformity; of moral nobility, not social respectability."

Dr. Martin Luther King said that.

Every day I've worked on this case over the past four years and the two months that I've spent with you, I've struggled every day with whether I have lived up to the trust that Joan Boice and Myron and their children and grandchildren have put in me, that I've borne adequate witness to the horror of what happened to Joan Boice.

Now it's time where I turn over to you what I've found, and what you've seen in the course of this trial. It's the point now where I turn over to you the story for you to judge why Joan died, what was behind it, what was behind this horrific death. And when we met two months ago, I said to you, if you were selected, our society would place upon you great power. In exchange for your service, you will have great power in this case.

Chief Justice Earl Warren, who was many years ago the Chief Justice of the United States, said, "Aside

from putting on your uniform to serve your country in a time of war, there is no greater service you can do as a citizen than to serve on a jury."

It's more important than voting. It's more important than anything else you can do as a citizen. And you now have that tremendous power. And believe me, there are people in this courtroom sitting in this gallery that wish they could be in your seat, to have some of this awesome power that you now have.

It is a very big responsibility, because now is the time for you to deal with what we have watched over the past eight weeks: The lie. It has been exposed to you, and you know what that lie is, and you've seen it, and it's your turn now to shine a light on that lie.

So let's look at the evidence now together of what that lie is. It is a scheme by Emeritus to defraud elders, which causes harm to the people who trust them. It is fraud by Emeritus. How have they carried out that fraud as we've seen it in this courtroom unfold?

They falsely advertised that they meet the needs of elder Americans. They do this in their brochures, in their licensing applications, in their plans of operation, and through the mouths of their directors and on their website.

They tell its staff to lie to the state. *Don't tell the state we're understaffed*, Jenny Hitt told us.

They tell their caregivers and their employees to lie to the families. *Don't tell the families we are*

understaffed. That was executive director Nancy Cordova in an in-service in January of 2008.

They tell its staff to admit residents without legally required physician assessments, the 602s. We heard a lot of evidence about that. *Admit them. Go ahead, admit these residents without them.*

Angela Neale, vice president of sales and marketing. Budgie Amparo, an officer of the company, the executive vice president of quality service, a pillar of quality for Emeritus. They say, keep admitting new residents and adding facilities, despite the fact that they know that they are understaffed, despite the fact that they know that they are harming people, despite the fact that they have noticed, and have had notice for years of this, despite the fact that the CEO and the founder of this company refers to the California division as a "shithole."

We've learned in this case how assisted-living facilities are supposed to work to keep residents safe, that there is a system devised by the state, a simple system of assessments and reassessments, or reappraisals, of having enough staff to meet the needs of the residents, of training the staff, and of supervising the staff. And if they do all those things, elderly people will be safe. Emeritus knew this. We've heard this from the very top of this company. They knew all these things that were required.

They knew, for resident care and safety, that they

had to have enough staff to meet their needs.

The staff had to be trained. They knew that, too.

They knew they had to do assessments.

They knew they had to comply with their own policies, their own rules, and they knew they had to comply with the law.

What is the fraud that we've seen in this case?

No assessments. Facilities willing to admit new residents having no idea what condition those residents are in before they accept them.

Never having enough staff. Chronic understaffing. Not enough staff to meet the basic human needs of these residents, and to keep them safe.

No training of the staff, meaning the staff are not going to know how to keep the residents safe, how to meet their needs.

Never enough supervision of the staff. How often did we see that from the top of this company down? Staff at every level is left to their own devices without support or direction, making it impossible to meet the needs of the residents.

"Emeritus is committed to your family." Remember that? Remember their promise painted on the walls of their buildings, on their website? "Our family is committed to yours." But the evidence is, the truth is, Emeritus is committed to your family's money. That's what they are committed to. They will do whatever it takes, breaking laws and regulations it promises to

uphold in order to get the license for Emerald Hills and all the other residential care facilities for the elderly that it operates in this state. It promises the state it's going to comply with its own plan of operations.

It promises to thousands of families and elders around the country that it's going to keep them safe.

Then we heard from Susan Rotella that as long ago as early as 2010 they were cutting staff again another 10 percent across the board. Why? So they could buy more buildings. So they could be number one. So they can meet the interests of their stock prices, breaking promises to families, to elders, to their own employees that you saw take the stand in this case. Vulnerable people. Our greatest treasures. Our mothers, our fathers, our spouses, our sisters, and our brothers.

Emeritus promises to take care of the family that they entrust in them as if they were their own, but instead it destroys lives.

Emeritus told Joan, *trust us*, and Emeritus told you to trust them, trust their officers, their directors, their managing agents, and yet when they came into this courtroom, they lied to you. They lied to Joan Boice. They lied to her family, and they lied to their own employees.

They lied about having specially trained staff. They lied about having a full-time nurse. They lied about complying with the regulations, developing

individualized care plans for anybody. They lied about having an activities-focused program. They lied.

They said this was going to be just like the Palms, and they lied about that, too.

They lied about documents that they had. They delayed producing documents. They wouldn't even produce Joan's own records to her family for more than six weeks so that they could be sent to corporate headquarters so they could look them over and decide what Joan was going to see, what her family was going to see.

Then we find out during this trial for the first time that there were a lot more records about Joan. There were skin sheets. There were care alerts, sheets about her care and treatment that you will learn. And you have heard from the judge yesterday in the instructions, in the law of this case, that they were supposed to maintain and keep those for at least three years.

They told Doris Marshall, their regional nurse, to not produce documents they weren't on the Emeritus logo, even though they related to Joan Boice's skin, her care, her treatment; documents that show that Jenny Hitt and other caregivers were treating Mrs. Boice's pressure ulcers for weeks before her family or her doctors even knew they existed. They didn't show us any of that damaging evidence.

And speaking of damaging evidence, an officer of the company, Budgie Amparo, and managing agents

including Lisa Hulse, the vice president of quality services, the two head nurses for the corporation and for California, they came into this courtroom, and they lied to you on a number of important issues.

They said they didn't have and couldn't produce the 10,000 -- the 2008 -- excuse me, the October 2008 CPR, the Comprehensive Process Review, the survey that was done two weeks after Joan was admitted. Now, why would they keep that from us? Why would they lie about that?

Well, we saw why, and we put it up on the screen. Because it showed, during the time Joan was there, what was going on in the Memory Care Unit. Staff weren't trained. Residents weren't getting activities. They weren't following their own program. They flunked, and they didn't want us to see it. They didn't want you to see it. They lied about that, too.

They lied about things like, we would never tell our nurses to go gray on the regulations, yet we put that document up there in black and white where Lisa Hulse said it, when a nurse, Peggy Stevenson, was asking for help about admitting residents into the facility who were not the level of care for what they could handle, and she was told -- Lisa Hulse directed the regional team to tell Peggy, *There are some times when we just have to go gray on those regulations. Doesn't she understand what her job is? She needs to call and talk to that doctor.*

Changes in diagnosis.

They lied and said there was never an urgent focus on sales. *Sales was never our number one priority*, and yet through documents that they did not produce, but came in another way, through an employee who had the courage to step forward and bring those documents to this courthouse. In fact, that's exactly what they did. Sales was their number one priority, and that came directly from the chief operating officer of the company. There it was in black and white for everyone to see.

They lied and said there was never a focus on increasing the level of care so we could increase our profits, and yet, boom, out it comes in trial, this big graphic sheet, Exhibit 264, increase level of care in 2008 by 25 percent a quarter.

So let's go through this evidence that exposes the lie. You've seen it. Let's just go through it. This part of the case, a lot of what you are going to be seeing now is not going to be given to you in the jury room. The exhibits will be, but not a lot of these things, so you might want to take notes if you are interested.

So this is what the regulations say: That "Every facility shall have, at all times, personnel sufficient in both numbers and competent" -- competent -- "to meet the needs of the residents to provide those services." And this was their policy. Their written policy said

they were going to have staff sufficient to make sure that at all times there were going to be staff available for safety and care, to meet the needs of the residents, immediately available when the resident requests or requires assistance. And we sure know now that was not the case.

What did their own expert have to say? Now, we saw some experts come in from the defense, and I want to remind you of a jury instruction the judge gave you, 5003, and an early jury instruction that she gave you before the case began about the demeanor of the witnesses. That is really important, for you to judge the demeanor of the witnesses that you saw. And that's something that you don't need to be an expert to figure out. We are human, and we have seen, throughout our lives -- we can tell when people are lying and when they are telling the truth.

Look at the demeanor of the witnesses, and remember back who argued, who was instructed by the judge that she was being argumentative, or he was being argumentative, to striking their answer because they were refusing to answer questions.

But there was an expert they had that they chose not to bring to trial, and that was their expert on the regulations, their expert on the standard of care, Mr. Grant. Let's hear what he had to say in quite contradiction to Dr. Fullerton.

THE COURT: Ms. Clement, could you wait just a

moment, please?

Sir, I need you to be seated somewhere.

Terrance, what I think I would like you to do at this point is put a sign up on the door saying not to come in until the next break. I don't want anybody distracting. Thank you.

Go ahead, Ms. Clement.

MS. CLEMENT: Thank you, Your Honor.

Mr. Grant. Mr. John Grant:

Q. Whose responsibility is it to comply with Title 22 regulations?

A. Well, the licensee.

Q. You understand that Emeritus needed to comply with its own policies and procedures, correct?

A. Yes.

MS. CLEMENT: The licensee, you will recall, is Emeritus. It is their responsibility.

Okay, everybody, let's look at understaffing, please.

What did Budgie Amparo tell us about staffing, what he knew as the head nurse? He told us he is the quality -- the pillar of quality services, so anything that has to do with resident care needs, he owns that.

And you will remember that in our jury instructions that Judge Judy Hersher read to you yesterday, we need to prove an officer, director or managing agent knew, directed, or approved of the conduct. Well, the evidence is, gentlemen and ladies of

this jury, that's where it came from. It came at the top of this company.

You know, someone once told me, when I was out at Bodega Bay at this wharf, that a fish rots from the top down. And this company, Emeritus, is rotten at the top. And didn't you see that in this courtroom right here? It started right here at the top.

They knew back in 2007, when they received Mary Kasuba's letter, that there were serious concerns about the safety of the residents at Emerald Hills. They knew there were huge shortages of staff in that building, that there wasn't enough staff to cover any part of the day-to-day staffing needs to give the residents their quality of care that Emeritus advertises since she first started working there at that company.

She sent that letter to the top of the company, to Dan Baty, to Granger Cobb, to Melanie Werdel, to the officers and directors, including Mr. Amparo. Did she hear back from anyone? Nope. Because what's the evidence been in this case? If you don't make your numbers, you are asked to leave. If you complain, if you use that ethics hotline, you are terminated. Or, as in Mary Kasuba's case, your resignation is accepted.

Now, what about regional director of operations for region 1, Rhonda Castleberg? She knew. She knew from Peggy Stevenson that there were problems with staffing still in August of '08. And she knew that those concerns continued after Nancy left and the new

administrator, the boat salesman, Rich Lee, came onboard in early 2009. And Doris Marshall told her that the other facilities in Region 1 were understaffed. She knew that. Any changes? Nope. Cut staff another 10 percent.

And what about the Emeritus staff at Emerald Hills? What did they tell us? Poor Nanette Read. Do you remember her? That med tech who works for Emeritus for, what, ten years, starts at$8 an hour, and now she is up to $11.15, the med tech who had to sue Emeritus at the Labor Board. She had to fight them for two years to get $200 of overtime. They couldn't afford to pay her that?

She told us that in the Memory Care Unit that you needed to have at least three people caring for those residents: at least two caregivers and a med tech, or three caregivers.

And what did we learn from Lynda Kittle, who we saw testify this week in video? That she complained to her supervisors at Emeritus that she didn't think it was safe to leave the residents in the Memory Care Unit with just one person watching them overnight. And we know that every single night Joan was there, that was the most they ever had to care for 15 to 17 people with dementia. Would you leave 15 to 17 toddlers alone with one person?

MR. REID: Your Honor, I think that's improper argument.

THE COURT: Overruled.

MS. CLEMENT: As a society, we wouldn't do that with 15 to 17 dogs overnight with one person. Or no one. What about the nights when there was no one there, when Joan was in her greatest need?

What did the directors admit about staffing at the facility level? Mary Kasuba, in 2007, ever since coming into this building, there's been a huge shortage of staff. Since she came to work at Emerald Hills, there has been not enough staff to cover any part of the day-to-day staffing needs.

She only worked there for a little over two months, and she had to come in and work the night shift three times because there was no staff to cover for that three-story building with a separate Memory Care Unit with one elevator. Come on. What do they take us for here?

Nancy Cordova. She had people -- she came and testified in this courtroom, and she testified in deposition that over the year and a half, she had employees complain to her that it was understaffed. Of course she did.

And Peggy Stevenson? Yes, she's complained. There wasn't enough staff on the floor, and the residents complained to her.

Now, the Peggy Stevenson we saw in the deposition clips was quite a different person than we saw in this trial after she became represented by Emeritus. That is

something you get to judge when you consider the demeanor of the witnesses, and I'm sure you won't forget Peggy.

What about Lisa Paglia? She is in a different region, a neighboring region, region 2. She's on these calls every week. She's in the buildings. And what does she come in here and tell us? What were the biggest concerns, issues, she was hearing from the executive directors? Understaffing problem throughout the company. It was wildly -- widely expressed in every building she went into, and she raised those concerns with the collaborative team. She raised them on the conference calls. She raised them in person.

And remember Danielle Woodlee, the concierge that worked the facility for a pretty long time? She sat there at the front desk. She was the one who was monitoring the pendant lights with the computer right there, and she talked about the turnover of staff. Five executive directors in her tenure of just over two years. Seven or eight nurses.

What about Jenny Hitt, the p.m.-shift caregiver who, on her shift, was expected to be in charge of the entire building with one or maybe two other people? All the time she had concerns that there wasn't enough staff to meet the needs of the residents at Emerald Hills. All the time. There wasn't enough staff to take care of the residents like they needed to. There were times there was just too much to do, and so much residents

that needed care.

And she had concerns about Mrs. Boice. There wasn't enough staff in the memory care to take care of her and her needs like she needed them to. You remember, she told us that she cried out for help about this, and she wasn't the only one.

And how did they respond to this notice of understaffing that went all the way to Budgie Amparo? What was the direction to regional? Well, corporate said, *Make those caregivers try multitasking. Do more with less*. They were told there was no more money to staff these facilities.

How did they respond to notice of understaffing with Lisa Paglia? She was told to stay out of operations. *Keep your nose out of that*. If the subject matter did not pertain directly to sales or my marketing function, to keep her mouth shut. But she didn't, did she? She kept pressing and pushing back. And what happened to her when she did that? She used that ethics hotline. [Snap.] Terminated.

What was Jenny Hitt told to tell the state investigators when the state came in? *Do not tell them we are understaffed.*

So now let's talk about the training, the evidence we saw in this case about training.

Budgie knew right from 2007 that there was inadequate numbers of staff who were trained to administer medications. He didn't even know if the

directors were being trained on how to staff to meet the acuity of the residents when they were telling them at corporate, accept higher-acuity residents, 25 percent more a quarter.

And they didn't even come up with a plan. In fact, we heard testimony from multiple people that Budgie Amparo said, *We will not have a staffing formula at Emeritus*. And he knew that them bringing in higher-acuity residents was going to require more training of the staff.

And Rhonda Castleberg, director of operations. She knew that training was an integral part of improving the quality of care and services to the clients. They all knew that.

And they knew that there was specific training requirements that California had for staff members, and there were additional training requirements for those staff members who would provide care -- who were providing care to residents with dementia, and that came from the state. They knew that.

They advertised that they were specialists in Alzheimer's care. Therefore -- and they took those residents with dementia -- therefore, they were required, at a minimum, to meet the basic, basic rules on training. Those rules include six hours of orientation specific to the care of residents with dementia within the first four weeks. Those included at least eight hours of in-service training on serving

residents with dementia within the first twelve months.

There were other requirements. Ten hours of care for the elderly physical limitations and their needs. The importance and techniques for personal care services. Resident rights. Policies and procedures regarding medication. Psychosocial needs of the elderly.

What do the regulations say? All caregiving staff shall have first-aid training and at least ten hours of initial training in the first four weeks, and at least four hours annually thereafter. And the training has to be conducted by someone who is knowledgeable, and at least meets the following criteria: A four-year degree, plus two years experience in elder care, or a license to work as a healthcare provider, such as a nurse or a doctor or a physical therapist, or at least two years experience at a residential care facility for the elderly administrator.

Why is that important? Because you heard, and you will see in Exhibit 32, and what you saw throughout the trial, is that a lot of these in-services were being led by Alicia Parga. Sweet gal. Didn't meet any of these qualifications. She hadn't even had training herself.

And where was this training supposed to be documented? In the personnel files. And it had to be kept for at least three years following termination of their employment. So what did we do? What was the evidence? We looked at the personnel files -- and you

remember Dr. Locatell testified about this. And look at who got what. The training according to the minimum state guidelines.

At the time that Mrs. Boice was there, nobody but Jenny Hitt had active first-aid training. They didn't have the initial ten-hour training. They didn't have the annual four-hour training. They didn't have the required dementia training. And we only have three that had had the Join the Journey training that Emeritus touted in all of their documentation.

Not Alicia Parga. Not a very nice gentleman, Alfredo. Remember him? He didn't have it. Dan Naylor, who was one of the people who was working in the building when Joan Boice fell on September 22nd. Jacelyn Monty. Anjelica Juarez. Hermalinda Alonso.

Two other staff members. What did they know?

Well, here is Lisa Hulse, the managing agent of the company. She knew that caregivers who were not trained either by the requirements set forth by the state and by Emeritus's own policy to meet the needs of the residents that Emeritus had accepted, that would be a dysfunctional facility.

And Doris told us those facilities were complaining that the staff were undertrained.

What did Susan Rotella tell us when she came onboard at the end of November 2009, and was prompted after she was internally whistleblowing about the problems in this facility -- in this state? Excuse me.

She told us that in her initial meeting at corporate headquarters, that they set out an edict: 10 percent staffing cut across the country.

She told us that since there had been no vice president of operations since Catherine Ratelle had been fired. They had been cutting staff more and more in California.

She told us that when she met, in her first two weeks, and toured the facilities, and met with regional and divisional people and facility-level people, that the number-one complaints were, we don't have enough staff. And we have numbers of vacant positions, regional positions, facility-director positions. That's not even talking about the direct-care staff. We have all these empty positions. And what was she told? *Cut staff more. We'll take care of you in your bonus. It's okay*. She pushed back, and she was told, *You are not a fit with the corporate culture at Emeritus*. Thank God for that. She wasn't. She was someone called in to turn around California, and she stood up, and she wasn't a fit.

Because, you see, the people who get to stay are the people who drink the Emeritus Kool-Aid. Those people are rewarded financially very well. But the people who care, the people who say, *I am going to stand up for these residents, I am going to stand up and do what's right,* they are gone.

Let's talk about supervision. Budgie acknowledged

it: You have to have directors who were actually being supervised. Castleberg and Hulse, they acknowledged it.

The staff were required to comply with the policies and procedures. Well, that takes some supervision. You can't just have them up on an Internet website. The staff has to have time to look at them, to be trained on them, to be supervised to make sure they are doing these things.

They had to be operating in accordance with Title 22.

They had to be supervised.

Both the directors and the caregiving staff and Lisa Hulse acknowledged, of course you've got to have sufficient staff in the building to meet the needs of the residents in numbers, qualifications, training and supervision.

And what did Jenny Hitt tell us? What kind of supervision was that poor girl getting when she told us about Joan Boice's bed sore on her bottom that she started treating since shortly after Joan fell?

And what kind of supervision was she getting from Peggy Stevenson, the nurse, when she told us that she was trying her best to take care of that pressure ulcer, that wound on her bottom?

She told us she wrote care alerts about it. Other people wrote care alerts about it. They wrote care alerts about Joan needing more care, and Peggy said, *Just don't let anybody know*. So for two months Joan was

sitting on that bed sore on her bottom without treatment, without pressure relief. So it was developing and worsening and deepening. And she was getting no professional skilled services for it. She wasn't getting any care for it.

Did Peggy remember Joan? You would think. You had a resident, and you were a nurse at the facility, the supposed full-time nurse. And we know she wasn't there full-time, that she had to split her duties to another building in Roseville, miles away, two days a week. You would think that a nurse getting these care alerts would be in there looking at Joan, calling the doctor, doing a reappraisal, caring for this woman, notifying the family, getting her help.

But we all know now the lie. "Close the back door." "The only move-out that is acceptable is death." "Keep them in the building."

Lisa Hulse acknowledges those regional directors, the vice presidents of operations, they all need to be supervised. The directors of the individual facilities need to be supervised. What kind of evidence did we see of that? I mean, we've got that one e-mail from Peggy, right, to Doris and Lisa, asking for help. Does Lisa even write back to Peggy? Nope. She sends out a director of cover-up to go out there and talk to her about going gray on the regulations, another part of closing that back door, getting all the residents in, filling those beds.

Here is Doris. She found out that her job as a nurse wasn't as Budgie Amparo had told her it would be. It had very little to do with nursing. It dealt more with what they considered to be closing the back door, monitoring move-outs, assisting with move-outs in the community. That was the biggest part. Of course it was the biggest part, because we saw those e-mails from early 2008, in the fall of 2008, from managing agent vice president of operations Catherine Ratelle. Sales are number one. Sales is your number one priority right now. Big push on sales.

The chief operating officer, in October of 2008, Justin Hutchins, a director of the company. Urgent. Focus on sales. Her [sic] job was regional director of cover-up. Wasn't that clear throughout this case, that's what this has been, the lie, the big cover-up?

And what did the supervision, the directors at the individual facilities, receive?

Nancy Cordova: "Did you know whether anyone from Emeritus was supervising your administration to determine if you were meeting the needs of your residents?" "I don't know if, or how."

We know that there were 165 unusual incident reports that were submitted by Nancy Cordova to the Department of Social Services in the 18 months she worked there. We heard testimony about -- and those reports had to be approved by the regional people, and then those reports would go to corporate. So they knew.

They had the resident-event tracking summaries. We heard through Nancy Cordova about all the falls that were going on every month, people going out with injuries, with fractures, with serious injuries, leaving that building.

Before Joan was a resident, while Joan was a resident, after Joan was a resident, we heard about that. And you will see in Exhibit 207 the vice president of quality services, the VPQS reports from 2007 through 2010, you are going to see this was happening across the state. This wasn't just about Joan.

And poor Alicia Parga told us she needed more direction. She needed more training. Of course she did. She was a sweet gal. Then Emeritus got ahold of her and had her come into this courtroom and testify about things that were clearly lies. How dare they do that to that girl? What are the promises? That she would come back, and could get a good recommendation or a job with them. How dare they do that to her?

What supervision did they get? Well, not one of the directors that we saw and heard from -- Nancy Cordova, Peggy Stevenson, or Alicia Parga -- none of them got an evaluation the whole time they worked there. What kind of supervision is that?

The law, the regulations, say that "The licensee" -- that is Emeritus -- "shall exercise supervision over the affairs of the facility, and

establish policies that conform with the regulations and the welfare of the individuals it serves."

No one at Emeritus supervised the staff. They were freewheeling. Why? Because everybody was focused on sales and marketing. That was their job. "Fill the buildings."

What about training for the directors?

Peggy Stevenson: "I had no training."

Nancy Cordova. The training she got was in sales and marketing.

Alicia Parga. She didn't have the training she needed to do the job as a memory care director, and she felt she needed more training for the staff. That was the support she felt.

Remember she testified that she was in that position as the memory care director about a month after she started as a caregiver? It was a year and a half into her job before she got any training on her job duties.

That's all part of the fraud, the representation that we are going to have people that are going to be running this Memory Care Unit who are highly trained.

And Peggy Stevenson, what type of training did she get when they first came onboard? She didn't think there was any training. Corporate never gave her any training on how to do her job. Was she able to ensure that the Memory Care Unit staff was trained? Nope.

During her tenure as the resident care director,

was she able provide in-service meetings to make sure training was provided to the staff? Nope. I mean, if they got training. *Don't tell the families we are understaffed. Just cover up a wet spot.*

I'll invite you to look at that in-service binder, Exhibit 32, and see the kind of training they got. One particularly disturbing training they received was, *Don't think you can get dibs on a resident, who is deceased's, personal belongings.*

What about:

Q. And it's Emeritus's job to make sure that they hire experienced and qualified personnel as directors to run their individual facilities in California's division?

A. That is correct.

MS. CLEMENT: And Ana de la Cerda, Seattle corporate director of quality and compliance, what kind of qualifications did she have?

Nancy. It was her first formal position, and yet we heard evidence that, for a building of this size, the administrator needed to have at least three years experience as an administrator in a building with over 50 beds.

What about the memory care director, Alicia Parga? Did she have any of the minimum-job-description requirements? She didn't. And yes, she was a sweet, caring gal, but she didn't have any of those requirements. She was in way over her head. But she

was cheap.

That takes us into the why, and what they knew.

Budgie, he knew that they never needed to accept a particular resident for care. However, if they choose to accept a resident, they are responsible for meeting that resident's needs as identified in the preadmission appraisal. And what does that mean? That came straight from the regulations.

What do you need to meet resident's needs:

Q. So when you were in the Memory Care Unit at night by yourself and you would have an aggressive resident, for example, the gentleman who was trying to find the milk, what would you do?

A. Sometimes I called my coworkers to see if he or she could find a little bit of milk in the kitchen, or he could come and replace me while I would look for some milk in the kitchen, but unfortunately the refrigerators were locked. It wasn't all the time that there wasn't milk, but when there wasn't any, the resident would make us go through very difficult times because he would scream so much that he would wake up the rest of them up. So what I did sometimes -- as a matter of fact, it was only twice -- I called my husband in the dawn, early, to see if he could bring milk from the store.

Q. Did that help?

A. Yes, thank God. Because it's something so incredible, but when he had what he needed, what he wanted, he would calm down.

Q. Did you ever talk to your supervisors about having milk available for this gentleman?
A. Yes. They knew it perfectly.
Q. And what would they do?
A. They would only say that they were going to have the things that we needed to have, but sometimes we didn't have milk or enough food for them for when they wanted to eat at night.
Q. Did you ever have problems with running out of supplies?
A. Yes.
Q. What type of supplies did you run out of?
A. Gloves, diapers, laundry soap, bags for trash.

MS. CLEMENT: What do all these things mean? No staffing, no training, no supervision? It means money.

Who was Mary Kasuba writing to Emeritus about in 2007? What did these other people complain about on these conference calls and ethic hotline calls? *We need help, Mr. Baty. We need more money.* That's what it was.

What does the regulation say about Emeritus funding its facility? They shall assure sufficient resources to care for the residents. What type of resources did they see they got? Zero for activities from the Memory Care Unit. What, four bucks a day to feed the residents? Bringing in nearly $9,000 a day in revenue just on that one building?

What about Dorothy Ting, the first week on the job

at Dan Baty's baby, Rancho Solano? What did she find when she looked in on the Memory Care Unit? The residents were being served out of silver dog bowls. And when she asked -- when she went to the regional director of operations, at that time Mr. Zimmerman, and she asked for money to buy the dish ware, the Fiesta ware, that this is what is going to help those residents eat, she was told there was no money in the budget for that.

Emeritus corporate. Because we learned during the trial that all the money that Emerald Hills and the other facilities get gets swept right up to corporate headquarters. They control the money.

No matter what you heard from Mr. Finden and from other people that they brought in to testify from corporate about how these people could go over their budget, and they could get more staff, well, we saw what happened to people who did that. They got fired.

Did Peggy Stevenson say she could do that? Nope. She said no way. She didn't have that authority. The nurse didn't have that authority. None of them did. Emeritus corporate underfunded under its assisted-living facilities, so they did not have the resources they needed to care for their residents.

So did Emeritus follow the law in its own corporate policy prior to accepting Joan? Did they hire enough staff to meet the needs of the residents? No. Did they train their staff to meet its residents' care

needs? No. Did they make sure there was enough staff to meet each of the resident's needs? No.

We know it wasn't just Joan. We heard testimony about a lot of other people. If you look in that Exhibit 207, you are going to see a lot of other people in this state.

Did they make sure there was enough staff to operate a safe facility? Are you kidding me? Two people at night for the entire building, a three-story building? How many times did that happen over and over again during Joan's three months there? No one in the Memory Care Unit at night on at least three nights in the month of November when Joan was at her greatest need? No, they did not. Did they supervise her caregivers and directors? No, they did not.

What happened? What choices did Emeritus make? They knew they needed to have staff training, supervision, and resident assessments, and they didn't do it, and the residents were harmed.

So why? Why? What is behind this lie?

Well, it's "No Barriers to Sales." Remember that? "No barriers to sales." "Heads in the beds." "Fill the building," even when they didn't have enough staff.

Remember what Nancy Cordova told us:

Q. Did you instruct your community relations directors that worked for you during your administration to continue to recruit new residents even when there was not sufficient staff to meet the needs of the residents

who were already in the building?
A. The expectation is that we were always recruiting to have residents move in.
Q. And whose expectation was that?
A. Regional, divisional, the company. Just the expectation.
MS. CLEMENT: Do you remember Melissa Gratiot, the young lady that came in? This was her first job in sales and marketing and long-term care. Remember how scared she was? Her first two sales, Joan and Maggie Boice, look what happened to them. She was so scared after a while working in that building.
The things that she saw and complained about:
There were no activities in the Memory Care Unit. The Memory Care Unit, one of her biggest concerns was it smelled of urine constantly. That there were bedridden residents, residents who couldn't get out of bed on their own in both the Memory Care Unit side and the assisted living side. That there were residents that she could recall in the Memory Care Unit like Maggie Boice who were blind. There were aggressive residents. We've heard that repeatedly.
Jenny Hitt, that little tiny Jenny Hitt, getting punched regularly. Maritza Morales getting hit. A resident in the Memory Care Unit Melissa Gratiot told us about who was in a wheelchair with only one leg.
How in the world do they think that you will accept that level of staffing? What did Melissa Gratiot

tell you? Not one time in her ten months' employment did they ever reject a resident for high acuity.

She told us about the conditions of that Memory Care Unit, and her concerns about one of the tours she gave, and she went in there, and here were the residents in the activities room, the TV room, the video room, whatever they wanted to call that, and they are all sleeping, and so is the staff member. I guess that was nap-time activity.

And when she complained, what was she told by her supervisor, Rhonda Castleberg, regional director of operations? When she complained about the cleanliness, the lack of training, the lack of staff, the concerns about residents falling all the time, Rhonda's response was to go in her office, shut the blinds on her door, lock the door, and sell the building.

That wasn't the only person who saw that type of thing happening. Alicia Parga:

Q. And you felt that the Emeritus corporate was putting filling the building ahead of the well-being of the residents and of your staff?

A. I don't remember saying that.

Q. Is that what you felt at the time?

A. Yes.

MS. CLEMENT: Lisa Paglia. She talked about how the executive directors and salespeople were under intense pressure to fill the buildings while she was their regional director. And she, too, was in intense

pressure to fill the buildings. This is when -- before and during the time Mrs. Boice became a resident.

And Melissa Malek, do you remember her, regional director of sales and marketing, region 1? She worked for the company for nine years, and when the merger happened with Summerville and they brought all those operations people over -- Granger Cobb, the East Coast CEO, Melanie Werdel, executive vice president of operations, Budgie Amparo, the pillar, the head nurse.

Lisa Hulse. What did she tell us? After the merge, it was more numbers focused. A lot of the pressure was on numbers and sales and marketing rather than resident care. She was a nurse, too. She had concerns about the pressure that was being put on everyone to just get the numbers, the numbers, the numbers. She felt like pressure was being put on the communities, and it would impair their ability to take care of the people who were there. And after she complained on the ethics hotline, she was told that most of her buildings would be taken away from her, and she knew she was out the door, and she left.

Now we are going to move over to what Emeritus was required to do before they accepted residents for care. They were required, under the regulations that the judge read to you yesterday, that they conduct an interview with the applicant -- that's the elder -- and their responsible person. That would be their family member.

They were to perform a preadmission appraisal,

obtain and evaluate a recent medical assessment, and then they execute the admission agreement.

You remember Ana de la Cerda, director of policy compliance, and a residential care facility for the elderly administrator for many years. Remember her testimony? *This is the order we do it. This is how it's supposed to be done. You do all these things first and then you sign the contract, and then you get the money*.

No one at Emeritus ever met Joan before they accepted her as a resident. They signed her up. They took the money. They got that move-in fee. They never looked at her. They knew they were supposed to do that. Here she is. Officer of the company. They knew. They never got her evaluated with a physician's report required by their own policy, the 602.

Here is their policy. You've seen it. This is Exhibit 118 if you want to look at those policies when you are deliberating. They must obtain it within the last 30 days.

Ratelle, the managing agent, vice president of operations, she said yes, we got to get a physician's report before we accept them. She'd like to see it within a week or a month.

And you heard Lisa Hulse on the stand. And she was waffling all over about that, didn't want to admit it. A year, six months, oh, whatever. Get them in the door.

What did Paglia tell us about in a conversation on a sales call? Do you remember this story, where one of the facilities in region 2 had turned away a resident who arrived on a gurney in the parking lot with none of the required paperwork, not a physician's report? It had been a sale, a hot lead that had been reported.

She got some heat on that, didn't she? The next sales call, Budgie Amparo himself, the head nurse, is on a sales call. What do nurses and sales have in common?

Mr. Amparo spoke about the lost sale. What did he say? *We have a no barriers to sales policy throughout the company, and this should never happen.* He said, *Our priority is to get heads in the beds.* Then he got on the stand. Do you remember this? *Heads in the beds? I don't know if I've ever heard that term before.*

How many people testified about Mr. Amparo with the "Heads on the beds?" There were a lot of them.

Why are these physician's reports so important? Even their expert, Dr. Fullerton, had to admit to this, right? He had to admit they do them in his facilities. He admitted that these are so important because they have to -- Emeritus must determine whether they can legally accept the resident under the law. Can they accept them?

It's important for the safety of the residents, because many health conditions, as you heard from Judge Judy Hersher yesterday, are restricted or prohibited in an assisted-living facility. It must be done by a

doctor, because only a doctor is qualified to diagnose the resident's medical conditions, which means that Lisa Hulse's direction to Peggy to call the doctor and get him to change his diagnosis, that was wrong. "Must assess the health and physical restrictions of the resident."

A resident's health and physical restrictions affect what the resident is able to do. This is going to determine what kind of care the resident needs. You need to know this before you take their money and sign them up and move their furniture in and have them come into your building.

Can you meet their needs? It's pretty basic. And it must be within 30 days. Because as we heard, the resident's health and abilities change. And Emeritus had its own rule that this happen within 30 days. Its own rule. They violated all these rules. They knew they existed, and they violated them.

And what other evidence did we see? And this is in evidence. This supported the Paglia, the Gratiot, the Malek testimony, the Ting testimony, that they were being told to admit residents, by corporate, without the licensing 602.

Remember Paglia talked about that at that meeting in Tracy? And this citation came out of Tracy in December of 2008. She testified about that fall meeting when Angela Neale, a managing agent, the vice president of sales and marketing, stood up and told them, *It's*

okay. We can admit them without the 602s. We don't need that. And when she got push-back, Angela Neale, people in the room were freaking out. There are executive directors going, *hey, that's my license.*

Don't worry. Corporate is going to back you. Corporate is going to back you.

And when Lisa Paglia had the courage to go to Angela Neale and tell her on the break, *Hey, we got a mutiny going on in that other room, this is scary --*

Don't you dare contradict me.

That's what she was told. And she was terminated shortly thereafter, walked off the job.

Of course, everyone at corporate denied this, right? But they had that document, all those documents. The testimony went straight up to corporate.

They never did a preplacement appraisal of Joan Boice before they accepted her. What was the evidence? Nobody interviewed her. They gave the documents to the family. Bring them in whenever. Bring them in a week or whatever. Bring them in after Joan was admitted.

And Kathleen filled those out, and Nancy Cordova signed them on December 17th. They didn't care about these laws or regulations.

"Heads on the beds." "Fill the buildings."

They had a policy that they are supposed to be determining the level of care before they accept them, and they knew. I mean, even Ratelle had to admit that the preplacement appraisal that was done by the family

alone and not signed by Nancy Cordova until five days after Joan was admitted did not meet either the legal requirements or Emeritus' own policy for preplacement appraisals. Hey, it's just paper compliance. Don't worry about that. Who cares about the law or the regs?

They never did a functional assessment of Joan prior to her moving in. They knew they were supposed to do that. Of course it was all over their policies. Ratelle admitted that. They have -- at a minimum, they have to evaluate their functional ability. And even Dr. Fullerton had to agree that they have to evaluate the suitability of the resident for the facility. That's before they move in. Because they have to see, do we have the staff, the training, the supervision to care?

They have to determine, does the resident have dementia? Can we -- are they going to need more supervision and assistance? Can they get in and out of bed independently? In other words, are they bedridden?

So you will see the definition. It's right in Joan's chart in the physician's report, in the 602, in this blank 602 that's been submitted into evidence that you will have in the deliberation room.

They have to be able to get in and out of bed by themselves, and will need extra care by the staff, and they will need help in case of an emergency. They have to determine if the resident can get out of the building alone without emergency. Why is that so important?

We've all thought about that.

You yourselves had questions that the Court asked the witnesses about that. How are they going to get 75, 80 people out of the three-story building with two people at night when you've got a delayed egress Memory Care Unit, that there is only one person, or nobody, and on the other side of building you might have one or two people for three stories?

They must determine if the resident needs assistance with all activities of daily living, because we know that's a prohibited condition. They have to determine, can they bathe, dress, use the toilet, eat and walk without assistance? They have to know that first.

It's logic. It's just common sense.

And then what about the care plan? Never did a care plan for Joan. The regulations state that "Within two weeks of the resident's admission, the facility staff shall arrange a meeting with the resident and the resident's family to prepare a written care plan, and a copy of that care plan will be sent to the physician, and a new care plan would be prepared whenever there is a significant change in condition."

Now, we know about what their claim was. Budgie Amparo. He talked about the Peggy assessment on the first day, that incomplete evaluation. He said that was a care plan. And we had a number of their own other employees say that wasn't a care plan.

Then they tried to say that Vigilan that was printed two months -- excuse me, two years after the fact, it was incorrect, wasn't signed. And if you look at that thing -- I encourage you to look at that thing. Look at the last page. That thing isn't a care plan. It's a release of liability.

Their own policy says prior to move-in, we are going to assess this resident, and we are going to create an initial service and care plan, and discuss it with the resident family, and they are going to sign it.

Didn't do that.

So, prior to accepting Joan, did Emeritus ever meet her? No. Did they ever get a recent physician's report of her condition? No. Did they do a functional assessment of her condition? No. Did they assess her care needs? No. Did they develop a care plan for meeting those needs? No. Did they do a preplacement appraisal of Joan? No.

Because these guys, this Emeritus Corporation, it spits at the law. It spits at the rules. It doesn't care, because they've got a fundamental conflict in the purpose of this company between what they say they are and what they really are.

As I told you in the opening, this is a real-estate-acquisition company. It's not a healthcare provider. It's not a residential care facility for the elderly. What did Budgie Amparo call it? It was like a hotel. It had to fill the buildings.

There were three big issues how they filled them:

"No barriers to sales." That means, bring them in. We are going to knock down any barrier we could possibly have to filling that building.

"Heads in the beds."

"Keep the back door closed." What did that mean, "Keep the back door closed"? Don't let anybody move out unless they are deceased. And didn't we see that in Joan's case? Didn't we see that she had prohibited conditions, restricted conditions, that she was inappropriate for that facility?

She was doing great at the Palms. The Palms was like night and day to Emeritus. And talk about your community standard. I don't know what Dr. Fullerton was talking about in his building in Marin or all the different facilities he operates. But the Palms, that chart is in evidence, ladies and gentlemen. I want you to take some time looking at that chart, and compare that to Exhibit 2, the Emerald Hills chart, and I think you will find the exact same things that Dr. Locatell testified to about the clear and stark contrast, and how you are supposed to run a building like this, and how Emeritus runs their buildings.

THE COURT: Ms. Clement, I think we are going to take a short break now for 15 minutes.

For those of you who are out in the audience, would you please wait until the jury gets out first? We are going to pick back up promptly at 11:15.

Leave your notebooks on the chairs. Remember the admonitions.

Let the jury go out.

MS. CLEMENT: 10 --

THE COURT: 10:15.

For those of you in the audience, please do not attempt to engage any of the jurors in any conversations over the break.

We are in recess for 15 minutes. Thank you.

[Recess.]

[Court Reporter switch.]

(The following proceedings were held in open court, in the presence of the jury:)

COURT ATTENDANT: Come to order. Department 45 is once again in session. The honorable Judge Judy Hersher is presiding. You may be seated.

THE COURT: All right. Ms. Clement.

MS. CLEMENT: Thank you, Judge.

Thank you, Terrance.

So how did it fill its buildings? Any way it could. That is how it did it. And what did it do to its poor people that worked in the buildings? It pressured those people.

Let's hear from Nancy Cordova.

(The following video excerpt was then played in open court:)

Q Okay. Did you feel pressure from corporate to keep residents in the facility who were high acuity?

A Yes.

(Video stopped.)

MS. CLEMENT: Joan became high acuity as a result of Emeritus' neglect. Now, we never once, in this trial, blamed a caregiver. And we heard from Susan Ruether, Joan's roommate's daughter, Maggie Boyce, how hard these people worked. We heard it from the caregivers, too; Maritza Morales, Lynda Kittle, Jenny Hitt. They knew. Emeritus knew. These were their directives. These were directives coming from corporate headquarters to fill the buildings, to violate the law.

And what did Emeritus know about Joan Boice? They

knew that there were CARE alerts that were being written about Joan but were never produced. Jenny, and she helped other people at the facility, other caregivers who had problems writing, she filled out CARE alerts that Joan needed to be moved out of the facility, she was too high of care, that she had sores on her bottom and on her arms and on her foot. But like other damaging evidence, that damaging evidence was withheld.

Did they comply with the regulations and their own rules regarding Joan Boice? Never. Did they -- after Joan acquired these conditions, did Emeritus transfer Joan to a higher level of care when she became bedridden? Remember, she was walking when she first came in with her walker. But because the staff did not have time or training to assist Joan to get into her walker, to walk with her, to ambulate with her, she was left in a wheelchair all of the time, day after day, with no pressure relief.

The staff wasn't trained. There was no training for the staff on skin care to prevent pressure ulcers. They didn't know. Those poor caregivers. I mean, how vulnerable were they? How were they treated? When Joan got a stage 2 pressure ulcer, did they transfer her? Nope. Stage 3? Nope. When she became dependent on the staff for eating and the staff weren't trained? Jeez, they were even told they weren't allowed to feed people. And how would they have even had the time? They weren't caregivers. They were doing laundry. They were doing housekeeping. They were supposed to be doing activities which, of course, that

wasn't happening.

And when Joan became totally dependent on the staff for activities -- all of her activities of daily living, did they transfer her out then? No, they didn't, because they were told to "close the back door." Keep that money flowing in up to corporate.

What did the Judge instruct you yesterday on what the law -- the regulations are? This is what Dr. Kathryn Locatell explained to you, too. That Emeritus can't sit there with their eyes closed and say we don't know what happened, we are a hotel. They must observe regularly residents for changes in condition. When changes such as unusual weight loss -- and the evidence is clear that the weight loss occurred at Emeritus.

Now, they are going to want to try to tell you this occurred over a long period of time, right? We have the last weight from Emeritus -- excuse me -- the last weight from The Palms, we have the first weight from Foothill Oaks. Now, their policy, they testified, was to weigh a resident on admission. It's right on the evaluation form. Didn't do that. They were supposed to weigh them monthly. Now, did they do it or did they not do it? Well, they never produced the records, so we don't know. All we know is that in those three months she lost 20 pounds.

So when there was unusual weight loss or a physical health condition was observed, the licensee, that's Emeritus, shall ensure that the changes are documented and brought to the attention of the resident's responsible

person. And their own policies say that, too, to notify the physician and the responsible person. And they are supposed to keep a record for each resident, that includes medical assessments, records of any injuries or illness, appraisals and reappraisals, and this record shall be kept for at least three years after the resident leaves the facility.

Now, you will remember that the family requested these records while Joan was still alive. They were denied them for many weeks while corporate had their hands on them. And the law -- the regulations say, The facility shall do a written reappraisal of the resident whenever there is a significant change in their condition and shall immediately bring, immediately bring such changes to the attention of Dr. Awan, the physician, and the family.

What changes in condition did Dr. Awan get notified on? Well, she wasn't notified of the fall, she testified to that. She wasn't notified about the abrasion. She wasn't notified about what the physician had written, Dr. Stanford, the emergency room physician. There is no evidence in the record that they did any treatments for Mrs. Boice.

There is evidence that Joan was having difficulty walking, that, in fact, Alicia Parga testified that she knew that the family had brought that up to her and that she had recommended physical therapy. You heard from Kathleen Boice about that communication she had with Alicia. And Alicia said that she would contact Kaiser and inquire about physical therapy, but she didn't. I mean, I'm not blaming Alicia Parga for that. She was in over her head. She had a

lot to do. She wasn't just the memory care director, 25 percent of the time she was being a caregiver without even the minimum mandated training for a caregiver or even a first aid certificate.

Immediately bring changes to the attention of the physician and the family. Well, let's talk about the next big event that's documented because we don't have a lot of events documented in the record because they just didn't keep records, even though we see that's what they are required to do. October 14th, 2008, little Nanette Read, med tech, she notices that Joan is having more difficulty bearing weight on her right foot and is having more frequent and intense pain. Dr. Awan immediately faxes back an order. Bring her in for x-ray of her right foot and ankle. Do they do it? Nope. Do they tell the family? Nope. Do they follow-up with the physician? Nope.

Where is Peggie? Has that been a big question in your mind throughout these case? It's like, where's Waldo? Where is Peggie? Where is this woman that nobody saw come into the Memory Care Unit and assess residents? There is no notes from Peggie. Where is she? Well, she is off doing sales and marketing and covering another building, right? She is filling the building. She is preventing move-outs. She is "closing the back door." That is what their stand-up meetings were about, right? You saw that flash meeting minute. You saw -- you heard from that testimony about what the stand-up meeting minutes were, hot leads, warm leads, cold leads, risk of move-out. That's what corporate cares

about.

Thanks, Erik.

Boy, we sure got a lot of push back on this regulation, didn't we? Ah, that October 14th, '08, that transfer, bring her to Kaiser for x-ray of her right foot and ankle, we didn't have to tell the family about that. We didn't have to tell the physician to follow-up. And, we didn't have to transport her ourselves. There it is. Provide transportation. Okay, they couldn't provide it. Could they tell the family? Nope. Let's let her sit in her wheelchair for another three weeks.

And what did Dr. Locatell say to you and what do you know as a human beings alive? It's common sense; you move it or you lose it. This woman sat for weeks in a wheelchair having more frequent and intense pain, unable to bear weight. What's the obvious reason why she couldn't bear weight? She had an ulcer on her foot. She had this growing bed sore on her bottom right where she sits, which Dr. Fullerton had to admit, well, that's how those ischial ulcers start, they start from sitting, unrelieved pressure, hour after hour, day after day.

So, after Joan's condition changed, did Emeritus follow the law in its own corporate policy? Did they notify Joan's doctor of all of her changes in condition? No. Did they notify the family of her changes in condition? No. Did they follow all of the doctor's orders? No. We saw those medication administration records, lots of holes there, no notice to the doctor. Did they reappraise Joan

after each of Joan's changes in condition? No. Did they develop a care plan with each of Joan's changes in condition? No.

Let's talk about bedridden. Oh, sorry. After -- aha. I apologize. After admitting Joan, did they reappraise her after she fell? No. We have the one evaluation after she was moved in, September 12th. After she was no longer walking, did they reappraise her, after she needed more care? No. After the uncontrolled pain in her right foot? Nope. After she got the pressure ulcers? Nope.

Now we will talk about bedridden. What does this mean? It means requiring assistance in turning and repositioning in bed or being unable to independently transfer to and from bed, except in a facility with appropriate and sufficient care staff. Well, we know that wasn't true. We know that they had a lot of people who were bedridden, and we know that the managing agents of the company knew it.

Catherine Ratelle, vice-president of operations, Melanie Werdel, officer of the corporation, they knew that if a resident was unable to independently transfer to and from bed and unable to leave the building unassisted qualifies as bedridden. They knew that bedridden means you need the assistance of one or more people to transfer in and out of bed. They knew that.

Boy, do you remember that evidence we saw in this case about -- that crazy evidence about all of the people in the building that -- that couldn't get in and out of bed? There

is a lot of evidence on this.

Thank you, Erik.

Nancy Cordova: People on the memory care side needed assistance getting in and out of bed and even on the assisted living side. And Nanette Read, she has got no dog in this fight, she still works there. What did she testify to? At any given time a third of the people in the Memory Care Unit need assistance getting in and out of bed, a restricted condition for residential care facilities for the elderly. But if your goal is to fill the beds and collect money, it's not a problem.

How many people on the assisted living side, what percentage of the residents at any given time needed assistance getting at least out of bed? At least one person. And we heard lots of testimony about residents who needed two people or more. Maybe a fourth or a fifth, 20 to 25 percent.

Now, that is a shocking difference to the testimony we had from the Defense's witnesses, isn't it? Remember Budgie Amparo? Oh, our residents, they are all independent, they go to the bank, they drive, they do all of this stuff. Even Alfredo testified about how independent people were. These were all people represented by Emeritus.

And what did the managing agent, the vice-president of operations, what did she testify to? That Joan was a maximum assist with transfers and she should not have been admitted to Emerald Hills without the appropriate staff at that time. And she knew -- we saw her testify that she knew

that there wasn't enough staff. She knew that Nancy was overwhelmed. She knew about the complaints. She attended a meeting with a family member and Nancy in early 2008. Remember that e-mail we went over and all of the list of problems that happened. And that e-mail is in evidence for you to read, all of the things going on. Everything that was still happening when Joan was there. They didn't fix any of that stuff.

Thanks, Erik.

(The following video excerpt was then played in open court:)

Q Have you ever complained to any of your supervisors at Emeritus that you didn't think it was safe to leave the residents in the Memory Care Unit with just one person watching them overnight?

A Yes.

Q And what was the response?

A They said there is another caregiver on the assisted living side, that they can always call for help.

Q Did it seem to you that that was not an adequate response?

A It seemed it wasn't a safe response, um, because anything on any given night can happen. And the assisted living side could be dealing with an emergency at the time, themselves.

Q And you have people in the Memory Care Unit that are two-people assist, correct?

A Yes.

(Video stopped.)

MS. CLEMENT: And what did Anna De La Cerda -- and what did Anna De La Cerda, the director of licensing and compliance, the head of policy for Emeritus at corporate, what did she tell you?

(The following video excerpt was then played in open court:)

Q When you say "sufficient staff", you mean that there be sufficient staff in the building to meet the needs of the bedridden resident and all of the other residents in the facility?

A Well, the bedridden resident obviously will need, um, more assistance than the rest of the population and, yes, they look at it as a whole.

(Video stopped.)

MS. CLEMENT: Stop.

The bedridden residents are going to need more help than everyone else. How many people did we hear from corporate, from Seattle, testify, That is not necessarily true. That is not necessarily true if they are bedridden they are going to need more help. Lisa Hulse talked about that. Oh, boy, they sure wanted to fight about that, didn't they? You don't need to be an expert to know that.

(The following video excerpt was then played in open court:)

Q If you have a multi-level building, you're going to need more staff because you want to have somebody on each floor at all times, correct?

A That's correct.

(Video stopped.)

MS. CLEMENT: The facility must not accept or retain

residents who have stage 3 and 4 pressure sores who depend on others -- or who depend on others to perform all activities of daily living. Their own policy, Resident's needs must be manageable within the physical and operational limits of the community.

So what happens when you don't do reassessments, you don't do the initial assessments, you don't have enough staff, you have untrained staff, you have unsupervised staff? People get hurt.

Oh, thanks.

So what happened to Joan? She was harmed. She wasn't alone. You heard about other residents who were harmed. And I would invite you to read the VPQS reports that Lisa Hulse was sending to Budgie Amparo every month, Exhibit 207. This is for all of the communities in the State.

No supervision at the community. Retention of inappropriate residents. Staff training issues. Wounds, pressure ulcers on residents. Failure to report incidents to the Department of Social Services, to the State. Residents' needs not being met because of lack of staffing. Residents restrained with apron strings to chair. Residents who are sexually inappropriate with other residents in the dementia unit. Bilateral wounds -- that means on both sides of the body. Bilateral wounds on heels substantiated. Falls with injuries. Medications not received for ten days or more. Retention of residents with unstageable pressure ulcers.

Ten percent of their buildings in California were in

non-compliance status with the State. We heard about those. What did they do about it? What did they do about that? What did they do about this fundamental conflict in the stated purpose of this company and the real goal of this company? They heard from so many people that worked for them, from families, from the State, what did they do? They never stopped admitting people. They didn't stop trying to fill the beds. They never stopped.

Dorothy Ting. She was asked to cut housekeeping and if she cut housekeeping staff, that just puts work on the caregivers and takes away from the residents. So when she refused, that's when all her troubles began. And you remember Maritza Morales, we just saw her testimony by video the other day, she told you what her opinion was about how many staff they needed in the Memory Care Unit. She said, Yeah, we can do it with just two caregivers if we didn't have to be the housekeepers and the laundry and do activities. They needed someone, a specialist in activities.

Remember Crystal Roberts testifying that that is what she wanted. Remember Crystal Roberts telling us about all of those great activities and the programming and all of that great stuff they were going to do. We never saw any evidence that any of that was happening. It certainly didn't happen for Joan.

And what did they do once they started getting people that they started to represent? They got them to tell us stories. Tried to make us believe stories about -- to

justify Emeritus' despicable conduct. And that is the only way you can describe it, it was despicable and it is despicable. What they did to their employees, what they did to their residents, what they do to families is despicable.

She doesn't work there anymore. She got fired, but she is now represented by them. And she got on the stand and we questioned her, just like we questioned Hulse and Amparo about what they were actually up to, and they lied. I asked her straight out, Were you told by the founder and CEO, Dan Baty, that he had no more patience for non-performance in reaching the EBITDARM, the profit goals? I have never heard that statement before, she told us.

How many times did she say, when I posed questions to her, then we showed her actual evidence of her writing, her actual black and white what she wrote, how many times did she say, That is ridiculous, that is ridiculous? Mr. Dan Baty has no more patience for non-performance because that's how they prioritize their goals at Emeritus. It is about EBITDARM. It's about profit. It is not about resident care.

She denied that her non-performance was at issue with Mr. Baty, but then we heard from Susan Rotella who told us exactly why she got fired from her new boss, Chris Hyatt. She got fired because she wasn't making her numbers. But unlike other people, she got a year's severance package.

And what did we hear from Anna De La Cerda about all of the turnover in California?

(The following video excerpt was then played in open court:)

Q And since you've been at Emeritus over the past, um five -- well, not quite five years, um, have there been at least four vice-presidents of operations for California?
A Um, I -- I would say that is accurate.
Q And would you say that's a lot of turnover for that position, vice-president of operations for the California Division?
A It is high for -- for Emeritus.
Q Okay. So -- and this goes back to what you had said earlier about problems with the California Division, that there had been high turnover in the director's positions, which would include the vice-president of operations; is that correct?
A That is right, that was the challenge.
Q Okay. And, um, has there also been a lot of turnover in the vice-president of sales and marketing position for California?
A Um, not as much as the VPOs, but yes.

(Video stopped.)

MS. CLEMENT: And what did Susan Rotella, who was hired from the outside, the first person that they ever hired at that level of the corporation, a vice-president of operations, what did she tell us? That she -- she was unanimously selected. Here she was, you saw her testify, open, direct. What was her demeanor? Was she dodging questions? Was she being argumentative? Nope. She put it out there for you. And what did she tell us?

At her first meeting with Mr. Baty his welcoming

remark was, "Ah, so you're the one who's going to run the shit hole." Now, what did that mean? How many people did we hear from who said that California was driving down the stock prices? And how did Emeritus respond to whistleblowers like Dorothy Ting?

Catherine Ratelle lied on the stand. I've never threatened an employee with termination. That's ridiculous. Her e-mail: I need to see immediate improvement or we will have to make change in the entire leadership at Rancho. And what was the improvement she was talking about? What is that exhibit? I will tell you the number if you want to look at it, it's Exhibit Number 285. June 26th, 2008. Wasn't hitting her numbers.

And even when Dorothy Ting wrote back and told her, You're wrong, you're not calculating this right and she made her case, she laid it out -- and Ratelle stood on that stand and said, Yep, she was right, I was wrong -- how did she respond? Whine, whine, whine. Did she respond to Dorothy Ting? Did she apologize to her? Well, she said she did. Dorothy Ting said she didn't. Does this look like somebody who apologizes?

Who is she writing to? The vice-president of sales and marketing, the head -- Audrey Withers, the head of HR. Who in human resources supports people? Is that not the human resources person's job. At Emeritus it's the hatchet job. Whine, whine, whine. And Lisa Hulse. Did any of those people go to Dorothy Ting's defense? Nope. Wasn't too long after that that Dorothy was fired.

And how did these advertised promises compare with the actual care? Do you remember how compelling Susan Ruether was, Maggie Boyce, Joan Boice's roommate's daughter, who visited almost every day? Based on your experience at Emerald Hills, do you believe they lived up to the advertisement of what the facility would provide? No. Was there any discussion of creating an individualized care plan for your mother when she first approached Nancy and Melissa about your mother living at Emerald Hills?

And do you remember Susan telling us how she explained to them in detail the care her mom would need because her mom had mild dementia and she was blind? She explained that to them. And Susan said there was never a care plan for her mom. I asked about that because there was -- one of the issues, one of the things they mentioned was that their nurse would workup a care plan for mom, but I was never given one. That's a regulation. That's what they are supposed to do. That is their policy. They spit on those.

Do you remember Danielle Woodlee, the concierge? She had a lot of courage coming in here, didn't she? She went all the way up and met with Catherine Ratelle about her problems, and Audrey Withers in HR, about the things she saw in the building, about pendant lights being off for 15 minutes to two hours at a time. She voiced that they were understaffed for the residents.

And what did they tell her? Well, we can't have a full staff without a full building. Doesn't matter about the acuity of the residents. It doesn't matter about the

level of care. It doesn't matter that we are pressuring people to accept higher and higher level of care residents so we can buy more and more buildings.

And how did Emeritus respond to these whistleblowers, and how did they do it in this courtroom? They attacked them, didn't they? Every single one. They attacked those people. And when you asked Jenny Hitt this question, was there incidents that she felt she should have reported elder abuse or neglect? She said, Yes. Now, I believe there should have been times when I should have taken my position as having a job -- I wouldn't have taken my position as having a job so seriously or being so worried about it and just going ahead and calling the ombudsman no matter if I was worried about getting fired or not.

THE COURT: Close the door.

MS. CLEMENT: They pray on these vulnerable young women that work in these facilities as caregivers. They pay them next to nothing. After years of loyal service what do they get, 11 cents, 26 cents an hour raises, sometimes never a raise, tell them they have to work overtime, double shifts, and more.

We can have the lights now, Terrance. Thank you.

Look at how Emeritus in this trial got witnesses that it now represents and how it got them to tell stories, make-believe stories to try to justify Emeritus' despicable conduct. They spent outrageous amounts of money to call in three medical witnesses. Three different medical experts who didn't even agree with each other, right? Whose

testimony wasn't supported by her own treating doctors or her records. They made up this complex story, Only happened at Emerald Hills, nowhere else. This strange and outrageous story of spontaneous ulcers that just magically appeared at Emeritus and couldn't be healed. They couldn't be cured. Nothing could have been done. I mean, my God, they might have well of said you could have put Joan in a closet. But she wasn't in a closet, she was in a residential care facility for the elderly and she and her husband were paying over $7,000 a month for care.

Undocumented strokes. That was another one of their stories. Remember Dr. Tindall, when I showed him what the EMT said up there, the EMTs that wrote, who were first on the scene when Joan fell, She could move all four extremities equally. And when confronted with that evidence, what did he say? Oh, well, we know that is false. The emergency room nurses and doctors, they were wrong, too. And even when Dr. Awan testified that she was guessing when she wrote that Mrs. Boice had a stroke, she didn't have all of the evidence. She didn't know what had been going on at Emerald Hills.

Emeritus comes in here and they say, it's okay to violate the law, to go gray on the regulations and their own policies. It's okay to leave 15 to 17 dementia residents alone at night. It's okay to leave them with just one person at night, night after night, with aggressive residents, sundowning residents, hungry residents. All the while there is these cries of help from the facility

directors, regional people, the vice-president of operations, from families, from the elders themselves.

Do you remember Susan Ruether coming in to see her mom, and they had taken away her pendant, and her mom is crying out, Help! Help! Help me? Did you see anyone from Emeritus come in here and accept responsibility for anything? Did you see them do anything in response to the flunked CPR that they had in 2007, the only part of which they could apparently find was the pharmacy record? Did you see them do anything in response to the 2008 CPR that they wouldn't produce to us? They lost the 2010 CPR too, I guess. And then in a remarkable stroke of luck Lisa Hulse blurts out in her cross-examination, I think it may have been actually in a question posed by the Court by you, the jurors, Oh, we had a lot of bad CPRs all over the State. Yeah, they did.

Amparo could have done something. Werdel could have done something. Baty, he could have done something. He could have cut loose with some more money. He could have let them have an operating margin that was something less than the 40-something percent that we saw with Mr. Finden. He is the CEO. He is the chairman of the board. He was copied on the same letter from Mary Kasuba that Mr. Amparo admitted to reading. He was blind cc'd or copied on the e-mail that Dorothy Ting wrote. Did he do anything? Nope.

And when -- by the time Rotella, Susan Rotella gets on board in late 2009, the State -- by now the State is finally, you know, coming forward and saying, hey, Seattle,

get down here to southern California, we want to have a meeting with you. February 24th, 2010, they have a meeting. Werdel, Amparo, De La Cerda, Lisa Hulse, the new vice-president Rotella is there. They have a pre-meeting with all of the new people and the regional people in southern California is all there. And what do they hear in that meeting? We have serious problems with understaffing. We have serious problems with training. We have lots of vacant positions. We have got trouble.

They go straight from that meeting into the meeting with the State. Do they tell the State anything about that? Nope. They march right into that meeting and they never say a word. And what does Emeritus say in response to all of this?

Rotella told you her new boss, Chris Hyatt, says, Well, your budget for 2010 is going to be the same as your third quarter budget for 2009. She says, Wait a minute. Wait a minute. Wait a minute. We have all of these vacant positions. They are highly paid positions. We can't do that. Don't worry. Don't worry. You do that, we will take care of you. Susan Rotella, we will take care of you. She said no.

Now that they are caught and they are here before you and this evidence is out, what do they say? They play the blame game. You know, it's the family's fault. It's Joan's fault. It's Myron's fault. Kaiser should have done more. Everybody should have done more. They didn't come right out and say that, but they said it. What have you heard from

the Defense? A lot of insanity, hasn't it been? A lot of circular arguments round and round just passing the buck. Just passing the buck.

So now I'm going to talk to you about Joan. Because, you know, what they were ultimately selling to Joan and to Myron and to the family was trust, right? Trust us. Trust us to care for your most special treasure, your mom. They have done nothing to earn their trust. They betrayed that trust and then they say it's the family's fault. It's the caregiver's fault. They accused them. They accused all of these people. Why didn't you report it to the State?

Joan could never defend herself. She was dependent on Emeritus. She trusted them, as did her family. They bought the lie. The family bought the lie. They didn't know what we know now. They bought the lie and the pretty building and the glossy brochures and the lovely talk by poor Melissa Gratiot whose first two sales were Joan and Maggie Boyce.

Clearly that woman was traumatized by what she had to do in her job to the point that she actually at the end of her 10 months, went out and got -- took the class to become an administrator and to learn all of the Title 22 rules that she had never learned in her job. She realized, my God, what has been going on in this place is insanity.

The family bought the lies that it was just like The Palms. It was going to be just like The Palms. That there was a full-time nurse. And we know that Joan was helpless, completely helpless in there.

Thank you, Terrance.

Joan and Myron Boice, they wanted to be together. Myron wanted to be with his wife so much that even though he didn't have to be in a assisted living facility, he wanted to be under the same roof with his wife all of the time. And we know from The Palms assessment and service plan, and we know from the family's experience, all of the things Joan liked to do. She had fun there. She got to do things. She walked around. They had activities. They had lots of staff there. People knew who the family was when they came in. They knew Joan. She loved being with her family, her children and her grandchildren. And her children visited her frequently. And they loved their mother. She liked to do painting and crafts and coloring.

I mean, we are not going to come in here -- and I have never suggested to you, and Dr. Locatell didn't suggest to, and this family didn't suggest to you, that Joan did not have dementia. She did. She was a human being. She was a mother, a teacher, a volunteer. She deserved to be treated with dignity and respect. It was her right. She liked walking outside. She liked walking around the facility. She liked to eat. And she loved to be with her husband.

But what happened to Joan? What happened to her? She got in to the facility, and she wasn't -- they weren't -- she was never appropriate. They didn't have anybody to care for her and we know that now. Those caregivers did the best they could with what they had, but it wasn't enough. So she quit moving. She quit walking because they couldn't help her to walk.

She had her initial fall because she was left alone in the video room at night, found face down on the floor, incontinent of bowel and bladder. Probably needed to go to the bathroom, there was no walker there, fell. Who knows how long she was down. How scary that was for her. How scary could that be for her.

So she started developing contractures. Her ability to move was gone. She was isolated. She suffered a lot of weight loss. And she developed pressure ulcers. And those -- we have learned from Dr. Locatell, a pressure ulcer is the medical name for a bed sore. It's tissue damage that results from the body resting in one place for too long. It can start to develop within two hours if someone doesn't move.

We know in Joan's case that it had been going on since shortly after her fall when she quit moving and was left in a chair. People who are immobile need someone to turn and reposition them to relieve pressure while in bed and much more frequently in the chair. Prolonged sitting in a chair, wheelchair requires much more frequent positioning to prevent the pressure ulcers. And pressure ulcers are almost always preventable by frequent repositioning.

This baloney about spontaneous pressure ulcers, come on. Tissue damage, if neglected and the pressure is not relieved, they will quickly worsen. Did Joan get any pressure relief? No way. All of the testimony, Lynda Kittle, Michelle Riley, these people, what did they testify to, Jenny Hitt, the family: In a chair, in bed. In a

chair, in bed. In a chair, in bed.

They are dangerous. They are painful and debilitating. They rob the body's strength as the body tries to heal itself. They rob the body of the protein stores. They are debilitating. They cause an elderly person, or any person, to struggle to live. They can require months or years of treatment. They -- pressure ulcers result in irreversible decline and can lead to death, as it happened in Joan's case, which is why Dr. Awan listed as a significant factor in her death pressure ulcers. She didn't list strokes, mixed dementia; pressure ulcers.

Thank you, Terrance.

COURT ATTENDANT: You're welcome.

MS. CLEMENT: Now they want to come in here and tell you that Joan's pain wasn't worth anything. Joan didn't experience any pain. And I am not going to show you those pictures of Joan's bed sores again. Exhibit 5041-A is a CD of the digital photographs if you wish to look at them and it is completely your decision because they are graphic. You can do so in the deliberation room. Those pictures were taken shortly after Joan was admitted to Foothill Oaks. There are no pictures of the later skin, but we see that despite these spontaneous ulcers that could not have been cured or healed, as Dr. Fullerton said -- and what did he say? Oh, they got lucky.

When I cross-examined him and showed that they did, many of them were healing, some healed completely and only

that horrible, horrible ulcer on her bottom that had gone untreated and unnoticed and no pressure relief for two months at least before it was ever brought to the attention of Charlene Farrack, the visiting nurse, by Alicia Parga on December 1st, that wound did not heal, but the damage had already been done before she got to Foothill Oaks. Because Dr. Fullerton had to admit, he had to admit that Joan endured treatments that included weeks of using a bleached solution, bleach in her wound. No pain there?

This deep festering wound on her bottom, that Kathleen described for you, went all the way around near to her -- Joan's vagina, that was tunneling. There was a tunnel from one side of it into the part of her body between her anus and rectum where her stool would come out, that that was leaking stool into the wound, and that Joan had to endure wound treatments to that. Think about how long Joan was suffering. How many times she didn't get her medications while at Emeritus. And was she even getting them? Weren't those records a joke?

I don't know about you, but in my life, the good times pass too quickly. But the times of pain, the times that we are suffering, those times last forever. Those are the times when we say, when will this end? Those are the times when every heartbeat sounds like a kettle drum. For Joan, every second must have been a minute, every minute an hour.

In this courtroom justice is measured in dollars. We talked about that when we first met. Emeritus took something from Joan Boice and from her family that did not

belong to them. They took Joan from her family and they owe her family a debt. They took from Joan her dignity. They took from Joan her ability to walk. They took from Joan her ability to die in peace and not covered with deep festering bed sores.

Not surprisingly, Emeritus is now trying to welsh on that debt. Not our fault. We are not responsible. Talk to our lawyers. They have had the benefit of what they took from Joan Boice and from her family for more than four years. Well, it's pay-back time, and you know what that means. They need to repay Joan for what they did to her.

I'm going to talk to you about some of the instructions that the Judge has given you. I'm only going to talk about malice, fraud and oppression. You can also make a finding of reckless neglect, but I think the evidence here is very clear and it is convincing, it is overwhelming that what Emeritus has engaged in in its scheme to defraud our parents is malicious, it is despicable, and it was done with a willing and knowing disregard of the rights and safety of others.

And a person or a corporation, because that's what we are talking about here, we are talking about Emeritus Corporation who was creating these policies, who was implementing these policies, who was ignoring the cries for help, who adopted and approved and ratified of this conduct, boy, if you didn't see it in all of the evidence we had before, we certainly saw it up here in this courtroom, didn't we? They acted with knowing disregard when they were

aware of the probable dangerous consequences of their conduct and deliberately failed to avoid those consequences.

Everyone from corporate testified in this case they knew they had to have enough staff, they had to train the staff, they had to have supervision, they had to have adequate funding. They knew that. They knew about these cries for help and they did nothing. Increase the acuity. Bring in more people. Fill the beds. "Close the back door". Lie.

Anna De La Cerda.

(The following video excerpt was then played in open court:)

Q Now, it's your understanding that once Emeritus has received a license to operate an assisted living facility in California, it's on an honor system to comply with the regulations and Health and Safety Codes, correct?

A That's correct.

Q So it's actually Emeritus' responsibility to make sure that it's complying with the regulations and Health and Safety Codes that govern it?

A That is correct.

Q It's actually not the State's responsibility to tell Emeritus how to run its operation, because once Emeritus gets a license, they've agreed that they're going to know what the regs say, and they are going to comply with them, right?

A That's correct.

(Video stopped.)

MS. CLEMENT: Oppression. Emeritus' conduct was

despicable and subjected Joan to cruel and unjust hardship in knowing disregard of her rights. Let's think about that. We know what happened in September and October, let's move to November, right? The nights when -- there is three nights we know of for sure -- there is not a single caregiver in the entire Memory Care Unit.

Now we know, no question, it's not in dispute, they knew about the pressure ulcer on the 4th. On the 3rd someone called and told the family about it. It's getting worse. They know it's a stage 3 on the 14th, but they don't even have a single caregiver in there. They know they have to reposition her. They know they have to float her heels. They haven't told anybody about the bottom ulcer yet. They don't have a single person in there.

The next day is the meeting with the family. Talk about despicable conduct. Takes the family two weeks. You heard from Danielle Woodlee how they were hiding from this family who was trying to get a meeting. Hiding from them. Got to "close that back door." Did anybody at that meeting pipe up and tell the family, oh, by the way, last night we didn't have anybody on duty watching your mom? That might have been information they wanted to know.

That is information the Kaiser nurses wanted to know because you heard through Dr. Fullerton, he read all of those Kaiser nurse's depositions and the Kaiser physical therapist, and they said that if they had known about the staffing conditions in that building, they would have reported that as abuse and neglect.

Bed sores are getting worse. Do they have anybody on the PM shift to care for people? No. They had two med techs outside the Memory Care Unit passing medications. That's what they had. One only on the 22nd. I think I misspoke there. But on the 22nd and the 29th of November things are going really downhill for Joan at this point, and they only have one med tech on the PM shift and no other caregivers. They have got to pass all of those meds. They have got to feed them dinner. They have got to give showers and change them. My God. The night shift of the 30th, this is the day of the one CARE alert they produce, they know for sure now she is covered with bed sores, no question, no staff then on the night shift.

And what about the days, the nights that there is -- you can leave that up there -- there is only two people in the whole building for the night shift? Two people for 75 or more residents. A third of who can't get in or out of bed. Many of whom are two person or more assist transfers. People with dementia living on the assisted living side. September 30th, only two people on the night shift. October 1st, two people on the night shift. October 18th, two people on the night shift. October 25th, two people on the night shift. October 30th, two people on the night shift.

November 7th, they know about the bed sores. They have only got two people in that whole building, and all of the testimony now is Joan is a two-person assist. November 30th, two people on the night shift. December 1st, two people on the night shift. Despicable conduct. Oppression.

That is oppression.

Fraud. That means Emeritus intentionally misrepresented or concealed a material fact and did so intending to harm Joan Boice. Well, how about all of those nights where there is nobody in there, is that a material fact? Would you like to know that about your mom or dad? Would we all like to know that? How about those fraudulent comments they made in their brochures and their representations in the tours that they gave this family? Despicable conduct. It is conduct that is so vile-based or contemptible it would be looked down and despised on by reasonable people. That's us. That's not highly paid experts, that's us.

This is just one pull-out of Exhibit 207 for you. Remember this new initiative to manage move-outs? Have the families come in for training to deter them -- training on how to care for their loved ones to deter them from moving out. Despicable conduct how it treated its residents.

Susan Ruether. There were times when she knew there was neglect. She thought she was there often enough that she could recover from it. She came in one time to be told by Lynda Kittle that her mother had been tied in her wheelchair. And we know from the 207 report it didn't just happen to poor Maggie Boyce, blind and her buzzer, her pendant was taken away from her. And I said, Why would they do that? And Lynda said, I don't know.

And the time she came in and found her mom laying on the floor on the linoleum, laying with no pillow, no

blanket, just laying on the floor moaning in the kitchen and the caregivers told her, Oh, your mom was acting up. Her mom didn't weigh 100 pounds. What was she acting up on? They couldn't explain that. How she couldn't -- if her mother couldn't get them to come by the button, she would be yelling and she would hear her when she opened the door, Help! Help! Help me.

And about the final blow when they kept putting her mother in a recliner, a restraint because she couldn't get out of it. Most likely they didn't have the staff. I mean, how would that be any different from any other day at Emeritus? She came down on a dresser that was across the room from where the chair was because she was blind and was trying to get out of this restraint and she hit her face and her teeth went through her cheek. And when she got there, to the emergency room, her teeth were sticking out of her cheek. Despicable conduct.

And they knew. They knew about this for years. Mary Kasuba wrote a very compelling letter in October of 2007 and that is an exhibit for you to read. Please read it. Total dysfunction in the way corporation mandates this building to be run. And you may remember she said, You can accept my resignation. You can ignore what I have to say and you can hire another nurse who will encounter the same problems I have, and these problems will happen again and again and again, and they did.

And what did they do? How did they respond to damaging evidence about Joan Boice? What did Lisa Hulse

tell her to do? Oh, they got rid of the skin sheets. Well, she was told there is only certain documentation legally you have to keep and that wasn't one of them. We have seen the law. Now you know that is not true. And when you ask -- the jurors asked her the question, Was she asked to destroy records, she said, Well, I was instructed if they weren't on the Emeritus logo that I didn't -- we didn't have to -- they weren't needed, we didn't have to produce them.

And what kind of environment did they create for the people who worked there, the caregivers?

(The following video excerpt was then played in open court:)

Q Okay. So on 9/17 --

(Video stopped.)

MS. CLEMENT: Wait. Wait. Oh, sorry. Sorry. I missed something. I apologize, everyone.

They hid damaging evidence. And what else was going on in the facility? And this goes to Joan's pain and suffering and this goes to the despicability of their conduct and it goes to the fraud and the falsification of her records.

Anjelica Juarez talking about Joan's narcotic, the morphine that she was supposed to be getting and we saw so many nights that she didn't get.

(The following video excerpt was then played in open court:)

Q Okay. So on 9/17 at 8:00 p.m. when you put your initials there on page 93, that meant that you gave Mrs. Boice her 8:00 p.m. dose of morphine?

A Yes.

Q Okay. So I'm showing you, again, Exhibit Number 11 for 9/17. And tell me what time you clocked out that day.
A On what day was -- 17? At 2:26.
Q So did you give Mrs. Boice her morphine on 9/17 at 8:00 p.m.?
A I don't remember.
Q Huh?
A I don't remember. I don't think so.

(Video stopped.)

MS. CLEMENT: So let's look at what she was looking at. Here is the narcotic count sheet, 9/17, 8:00 p.m., there is her initials. Her time detail report. She was gone. What does that tell you about those records? What other falsifications did we see in the records?

Do you remember Melissa Gratiot, the training records? Remember that questioning she got from Mr. Reid, accusing her of lying about having this on-boarding training? Remember this document? We went through it and she was so confused up there on the stand. She kept saying, I didn't get this. I didn't get this.

Erik, can you make that yellow -- bring up that bottom right corner, please? Bottom right. Thank you.

They even -- they even documented there that they gave her this training. Not only was Nancy Cordova -- she hadn't been there for, what, seven or eight months now, she wasn't even there yet anymore. Melissa Gratiot wasn't even there anymore. And this was her actual on-boarding checklist that she took with her when she left the company as part of her

personnel file. It's all blank. Falsification. Fraud. Despicable conduct.

Let's see what kind of environment they created for those caregivers. Susan Ruether was there almost every day and she felt bad. She felt bad for them because she knew that they were just overwhelmed. They just can't do it. They just can't keep up with it. And that was pretty much an every day occurrence. And what else did Susan Ruether tell us?

She told us about being in the room, her mother's room, Joan Boice's room, during the time that these caregiving staff were trying their best to treat these bed sores on Joan. Unlicensed caregivers. And that they told her, This is the worse and we don't know what to do. And they would be trying to clean the bed sores while she was sitting there. And it would take them maybe an hour, an hour and a half just to roll Joan over and get her to where they could get to the bed sores and get her out of bed and into a wheelchair to a meal at that point.

They were overwhelmed. We just can't do it. We just can't keep up with it all, and that was an every day occurrence pretty much. Despicable conduct. Oppressive conduct. Malicious conduct. Fraudulent conduct. And what did Danielle Woodlee tell you? One person is just one person. She didn't feel like she could do it when no one else above you wants to help you.

What did they know? And what was Emeritus' true position about what they were supposed to be doing?

Ronda Castleberg.

(The following video excerpt was then played in open court:)

Q Well, isn't the primary responsibility of assisted living facilities is to meet the needs of the residents?

A I would not say that.

(Video stopped.)

MS. CLEMENT: Alicia Parga.

(The following video excerpt was then played in open court:)

Q How did that make you feel working and -- as the Memory Care Unit director with not enough professional eyes and -- medical eyes in -- in your building to know that Emeritus at corporate was spending their money and focus on buying more buildings?

A Um, I felt like we needed to work together to make our facility better.

Q Did you feel like the priorities were upside down at corporate, that they should be focusing on taking care of the residents they already had rather than buying more buildings?

A Yes.

(Video stopped.)

MS. CLEMENT: What did they know?

Melanie Werdel, officer of the company, executive vice-president.

(The following video excerpt was then played in open court:)

Q Did you have multiple people at the divisional, regional and facility level in California between the time that you first started in Emeritus through the meeting that

you had in February of 2010 with the Department of Social Services Community Care Licensing --

A Yeah.

Q -- report to Emeritus headquarters that there was serious problems in staffing and training in Emeritus facilities?

A We did.

Q Did Emeritus at corporate headquarters ever make a decision or even consider stopping admitting new residents into Emeritus facilities in California until you got the problems in California sorted out?

A No.

(Video stopped.)

MS. CLEMENT: What did Lisa Hulse tell us about what Emeritus has done in response to this notice, in response to what happened to Joan Boice?

(The following video excerpt was then played in open court:)

Q Have there been any policy changes at Emeritus as a result of Mrs. Boice's developing multiple pressure ulcers in the Memory Care Unit at Emerald Hills?

A No.

(Video stopped.)

MS. CLEMENT: Thank you, Terrance.

COURT ATTENDANT: You're welcome.

THE COURT: Ms. Clement, Mr. Reid, could I see you for a moment, please?

(Sidebar conference was held.)

MS. CLEMENT: Much of my life I have been dealing with

things that scare me and trying to find whatever it takes to get past that. That's what we do. Much of our society discourages us from standing up, from standing out. We are encouraged to conform, to give in, to go along, to not get involved, right? Well, this is a story about a family that had the courage to come forward and to fight for four years to bring this story, a story Emeritus fought very hard from getting here as you heard through Eric.

Martin Luther King once gave a sermon about the good samaritan called, The Knock at Midnight, where he spoke about events on the road to Jericho, a dangerous road from Jerusalem to Jericho, and about a man, a Jewish man who had fallen on the side of the road who had been attacked by thieves and rock, was kicked to the side and left to die or for the next band of thieves to come along.

And a priest walked by and didn't stop. And the Levite, the church official, walked by and he didn't stop. And then along came a stranger, a man from Samaria. Now, the Samaritans were the enemies of the Jews, but the Samaritan stopped and he picked up the injured man and he put him on his horse and he took him to the inn nearby and he told the innkeeper, Here's the money to care for him.

And what Dr. King pointed out was that the priest and the Levite, the people who do not want to get involved, have been asking this question, they have been asking themselves, If I stop, what happens to me? Whereas the Samaritan, the good Samaritan -- that is where we get that term, the good Samaritan -- asked, If I don't stop, what will happen to

him?

These are times when we are faced with decisions that do not come along very often in our lives. These are not easy times. These are times that will call on us to be human beings, to remember what our parents taught us, what our family and friends, our mentors have taught us about what it means to be human.

Dr. King said that, The measure of a person is not taken in times of comfort and convenience but in times of conflict and challenge. They call upon us to stand up and to stand out. They call upon us to either sit down or get up and dance. You all are in a time like this right now collectively. And Emeritus does not think you have what it takes to stand up and to stand out and to tell them that their conduct was malicious, fraudulent, oppressive, despicable, neglect, that it caused -- was a significant contributing factor in causing Joan Boice's death and that they owe a debt.

They issued a promissory note to Joan Boice and her family to keep her safe and that note has now come due. And I refuse, unlike Emeritus, to believe that the bank of justice is insolvent, that it -- that the justice in this courtroom is bankrupt. I don't believe that for one minute.

Dr. King went on to say, I have a dream that one day my four little children will live in a world where they will not be judged by the color of their skin but by the content of their character. I too have a dream and a hope. I have a dream for the Joan Boices, the Maggie Boyces, the other

elders, our brothers, our sisters, our mothers and fathers, people with disabilities, who can teach us more and have taught us more about what it means to be human than anyone we see on TV, these pop stars, these athletes, I have a dream that one day, today or tomorrow, through your verdict Emeritus will be judged not on the discounted dollars that they want you to put on people who have disabilities like Joan Boice, but on the currency of their courage. Because anyone who thinks that it wasn't courageous what Joan Boice went through, what her family went through and has gone through to be here and to get here today, has another thing coming.

And on behalf of Joan and Myron, and Eric, Kathleen and Nancee and Mark Boice, I thank you very much.

Thank you, Judge.

THE COURT: Ladies and gentlemen, we talked yesterday about taking a shortened lunch hour. Leave your notebooks on the chairs. Remember the admonitions. We are going to start promptly at one o'clock.

Please remember the admonitions. Do not discuss this case among yourselves or with anyone else. You haven't heard the other arguments in the case. I will see you at one o'clock.

People in the audience, please wait until the jury leaves. We are in recess.

If I could ask everyone to please leave the courtroom. Thank you.

(Lunch recess.)

THURSDAY, FEBRUARY 28, 2013

AFTERNOON SESSION

--oOo--

The matter of JOAN BOICE, by and through her Successor-in-Interest, ERIC BOICE, and ERIC BOICE, NANCEE BOICE, and MARK BOICE, individually, Plaintiffs, vs. EMERITUS CORPORATION dba EMERITUS AT EMERALD HILLS, Defendants, Case No. 34-2009-00063714, came on regularly this day before Honorable JUDY HOLZER HERSHER, Judge of the Superior Court of the State of California, for the County of Sacramento, Department 45.

The Plaintiffs, JOAN BOICE, by and through her Successor-in-Interest, ERIC BOICE, and ERIC BOICE, NANCEE BOICE, and MARK BOICE, individually, were represented by LESLEY A. CLEMENT, ASHLEY BAIRD, SEAN LAIRD, and VALERIE DAWSON, Attorneys at Law.

The Plaintiffs ERIC BOICE, NANCEE BOICE, and MARK BOICE were present.

The Defendant, EMERITUS CORPORATION dba EMERITUS AT EMERALD HILLS, was represented by BRYAN R. REID, RIMA BADAWIYA, and KIM M. WELLS, Attorneys at Law.

Also present on behalf of the Defendant, EMERITUS CORPORATION dba EMERITUS AT EMERALD HILLS, was JANET E. McKINNON, Vice Present of Legal Affairs; LISA HULSE, Vice President Quality & Risk Management; and HOLLY FORD, Trial Consultant.

- - -

- - -

The following proceedings were had in the presence of the jury:

THE COURT ATTENDANT: Come to order. You may be seated.

THE COURT: Mr. Reid?

MR. REID: Thank you, Your Honor.

CLOSING ARGUMENT

MR. REID: Good afternoon, ladies and gentlemen.

THE JURY PANEL: Good afternoon.

MR. REID: It's a real pleasure to be able to speak with you again a couple months later, and I just wanted, on behalf of myself and my partners and my clients, I want to thank you for your attention and your patience and the time that you've committed to all of us in this journey for justice. We are all in your debt, and this system only works because of people like you, so thank you very much.

I want to spend my time with you talking about how I think the evidence in this case comes together, and first I'm going to talk about just some of the preliminary facts, thoughts, that I have.

First of all, it is not disputed that the loss of a loved one is tragic, and so we come into this courtroom with heavy hearts. We all do. And Joan Boice was afflicted with very debilitating diseases, and her exit from life was not -- it's one we all hope that we don't endure, or we don't have to endure with our loved

ones. But it is a loss, and it does cause pain, and I know it causes pain to the Boice family.

I didn't know Joan Boice, but what I think has come across during these two months is, you know, I always -- we are four and a half years removed from these events, four and a half years, and tremendous amounts of litigation, of emotion, anxiety, probably anger. And what happens in that time frame -- and I am not just talking about the Boice family, I'm talking about everybody -- our memories become challenged. We start to remember things through this haze of emotion that we've experienced over four and a half years.

So as I go through my comments today, I just want you to have a thought in mind, which is, actions speak louder than words. Let's look at what people were doing. Let's assume -- and there is no reason to not assume -- that everyone who was involved in Joan Boice's care back in the fall of 2008 were decent, caring, concerned, and were trying to do the right thing for her. There is no reason not to believe that. That goes for the Boice family, that goes for the Kaiser people, and that goes for the folks at Emerald Hills.

So actions. Let's look -- let's go back in time and look at what people were doing, and then we can put into context what people are saying. And then we think about, wow, maybe what's coming out on the witness stand is the truth as people now remember it four and a half years later, after tremendous amounts of litigation and

anger and hostility. And, you know, that's got to have a warping effect.

I always like to think about, you know, if this was a simple car-accident case, and driver A is suing driver B, and you have the testimony of driver A, and you have the testimony of driver B, who all experience this event in a very dramatic way, and then you have witness C who was standing on the corner pushing the button, you know, it would a dramatic moment for witness C, but they didn't live it.

So their memories might not be quite as warped. And I don't mean that word in a bad way because their memories would probably be clearer. And in some ways, folks, I kind of think of you as the people pushing the button on the corner, okay? You don't have a stake in this trial. You don't have any affiliation or affection for the plaintiffs or Emeritus or anyone else.

And I know that you are here. You've spent two months with us with the sole purpose of doing the right thing and doing justice. So you are the people on the corner pushing that button, and I am going to give you my perspective of what that means.

So in that vein, the first thought I have, is that while we've heard some very dramatic testimony about prisoner of war and Nazi war camps and horrible, awful trauma that the family has suffered, they claim -- and I'm sure that they are telling us the truth as they remember it today -- what did they do at the time?

They didn't -- if the Palms was this wonderful, lovely place, and Emerald Hills was this horrific place that stunk and provided nothing and ignored Joan Boice, when Myron Boice was visiting every day, and Eric and Kathleen Boice were trading off every day, then who wouldn't move their loved ones? Who wouldn't? They can go back to the Palms.

What we need to keep in mind about assisted living is that, you know, these are persons, and if you are not happy, you vote with your feet. You are up, and you are gone, and you move, okay?

There was no testimony, not any testimony of any desire to move out of Emerald Hills. And as a matter of fact, the testimony -- there were some, you know, concerns. And as we talk about it, we'll understand why. But even after -- even after Kaiser comes in and the wounds are starting to be developed, there is still an effort by the family, and a desire to keep Mrs. Boice at Emerald Hills. And that action speaks volumes about what was really going on, and about what these loving family members were really experiencing and seeing and smelling and hearing.

They didn't try to move Mrs. Boice. They didn't -- we saw yesterday, you know, they never took a complaint beyond Nancy Cordova or Peggy. They never reached out beyond the community. That implies, you know, some challenges and some observation and some requests, but not significant, you know, holy cow,

what's going on? What are you doing to my mother?

And then even after they are aware of these wounds and they move to Foothill Oaks -- you saw the testimony yesterday. You know. There was no, Dr. Martin, what in the world did they do to my mom? Why does she have these wounds? What's happening? Tell me. Did they cause this? Did they do something wrong? There is no inquiries at all, and I have to believe, ladies and gentlemen, that the reason for that is because what was occurring was expected.

Remember, and we'll see it, but remember all of the -- there is multiple times when doctors spent time, lots of time, long discussion with the family about what to expect. The actions suggest that what they were experiencing was not surprising to them. It wasn't shocking, and it shouldn't have been.

So I think that indeed the actions are consistent with that understanding of doctors doing their job in cautiously informing the family, look, your mom has Alzheimer's disease. This is what's going to happen.

Now, this one, this one is interesting, and we'll see some of the documentation. We have very, very sophisticated people here. Eric Boice was a police officer for how long was it? Almost two decades. And Kathleen Boice is a very sharp, sophisticated gal with very -- with lots of responsibilities in working with regulatory agencies. And so no call to anyone? No call to Adult Protective Services, the Department of Social

Services? Nothing. Again, that action is consistent with an expectation rather than shock.

And remember the testimony that we heard several times? I think this case could make a difference. That's what would make a difference, an immediate difference, if in fact there was a problem at Emerald Hills. That phone call to that ombudsman or the Department of Social Services or the police or some agency would make an immediate difference in the quality of care, if in fact what's been alleged in this trial was going on.

Now, this is where I personally get bothered.

Within two weeks of leaving Emerald Hills, less than two weeks, the family decided to go in a different direction, and they were already in Ms. Clement's office. And Ms. Clement already had Dr. Locatell onboard. And the way this case has come down over four and a half years -- the case is four and a half years old, and it's been in Ms. Clement's office for four and a half, minus two weeks, years, rounding off.

And so we have people coming in who -- who, you know, Melissa Gratiot, who just, you know, she didn't want the to tell us that she had been in part of this advocacy team, but she had been. And she was there at the time.

I want to point out something here that will come up on another slide, but these are actually my notes, and I apologize. I do this. This is -- if this goes

down, we're in trouble, because I don't have any other notes. And it's not going to be bells and whistles. This is just my thoughts.

So, you know, I want you to bear in mind that I have -- we have not been able to explain everything. We haven't come in here with a perfect chart or, well, here is the care plan, or here is this or here is that. We've come in and said, we're not sure.

The records. You heard Doris Marshall, who is kind of all over the place. We're here. We can't answer everything. But if we were falsifying records, if we were bad people, don't you think that, you know, we wouldn't miss a beat? We would go back and start filling out documents. And Dr. Locatell said she's seen it. It happens. We're here with our hands out saying this is what we have, and we are not making excuses, but we are not falsifying records either.

And then when we get to the records themselves, holy cow, we'll take a look at them. If we were going to falsify them, certainly we would do a better job than what we've seen in the trial. We would certainly fill out all of MARs.

So within two weeks we have this march going in a different direction in pursuing a lawsuit, in working it up. And even after the family went to Ms. Clement, and Dr. Locatell was onboard, there still wasn't a call to the Department of Social Services or Adult Protective Services or the police department or any regulatory

agency that could make a difference, because they are starting to pursue different remedies, the remedies that are going to be asked for here this afternoon.

It's been in the works -- this case has been in the works well before Emeritus ever knew there was a lawsuit pending, since December of 2008.

And here is the key, and this is what I told you in opening statement: Remember, I said perhaps what you want to do is take your notepad, and draw two lines right down the middle, and in the first column label it "elder abuse neglect" and in the second column, label it "wrongful death," and in the third column label it "N/A," not applicable.

This case is about Joan Boice. It's only about Joan Boice.

Remember, we looked at these yesterday. These are the verdict forms. The one on the left is the elder-abuse neglect form. Did Emerald Hills and Emeritus abuse Ms. Boice? We'll talk about that. That's question 1.

That's clear and convincing evidence, and these are recklessness, malice, oppression, fraud, and its authorization, ratification by a corporate officer, a managing agent. That's the one question that the plaintiffs have asked you to answer.

And number two, the second verdict form is, did Emerald Hills, Emeritus, cause Mrs. Boice's death? They are only related to Mrs. Boice. And those are the only

routes to a remedy that the plaintiffs have offered you in this case. There is no other remedy route available. And when you do your duty and you follow the law, you are going to see that we are going to run into some major, major roadblocks to doing what the plaintiffs want you to do. Not applicable.

"Heads in beds." We heard I don't know how many days of testimony, of confrontational testimony, about "heads in beds." And really, no one credible -- lots of times you folks asked the question. These people at Emerald Hills hadn't heard of this term, "heads in beds."

You saw the budget. The budget wasn't for, you know, a hundred percent occupancy. It was for flat occupancy. And bottom line is, the decision for Mrs. Boice to move in had nothing to do with this. Nothing. "Heads in beds."

PRN medications. How much time did we spend talking about PRN medications, and administering PRN medications, and having witnesses confronted about PRN medications, and what do you do, what's your training?

Mrs. Boice didn't have PRN medications. She didn't. We could have been done probably two days earlier if we would have recognized that PRN medications are not an issue.

Insulin injection. The same thing.

"Close the back door." Now, that one is really remarkable, because as we look at the evidence -- and I

am going to walk you through it in a little while -- this was the opposite of "closing the back door." Emerald Hills swung it open. They said -- remember, we'll see it -- corporate says no, she can't stay, even on hospice, not with a stage 3 wounds. They opened the door. This whole notion of "closing the back door," whether it's true or not -- and we've heard testimony about it -- it played no role in this case for Joan Boice. None.

The VPQS, Exhibit 207. Ms. Clement asked you to go through this, and you are welcome to go through it.

I had to make a decision. Plaintiffs' case took six weeks to put on. I had about two. And I understood that this case was about Joan Boice. And you've seen how much goes in to defending one case. Or not even defending it. Just talking about it. All of the complexities, all of the records, all of the experts. It is not a simple task that you have, that I have, to analyze and evaluate the quality of care that someone gets in these circumstances.

The VPQS reports have probably hundreds of these circumstances. Hundreds. I had to make a decision. Are we going to finish this case? Are we going to talk about Joan Boice? Yes. That's what we are going to do.

The VPQS reports are an unfair red herring designed to accomplish something other than helping you get to justice in this case concerning Joan Boice. And if you decide to look at them, think about where that

information came from. It came from my client. They are tracking it. Why are they tracking it? Why in the world would they be tracking their own despicable conduct? They are tracking it to try to improve, to look for areas to do better, to understand trends. That's why they are doing it.

And those VPQS reports, any potential allegation or issue that goes on there, it doesn't mean anybody did anything wrong. It's going to be a Joan Boice circumstance. Maybe there was an error. Maybe there is something that can change. Or maybe not.

The majority of the plaintiffs' witnesses in this case knew nothing about Joan Boice. Six weeks of testimony we heard, and very few of these people offered anything about Joan Boice. As a matter of fact, it took us a good hour and a half of opening statement to hear anything about her, and it's her case. It's about her care. Weeks of testimony. Weeks of testimony that had nothing to do with Joan Boice.

So I put up what I call the "N/A" page there. And you know, let's talk about milk, okay? That was dramatic testimony from a witness who, by the way, can speak English fine. She can do her job. But when she's called to give a deposition and put under oath and be questioned by a very aggressive lawyer, she opts to have an interpreter, and nobody should blame her about that.

And I will tell you what, ladies and gentlemen. I don't think it had to do specifically with, you know,

whether she can speak English or not. I think this is just trying to make -- trying to put some impression in your mind.

But milk, okay? They ran out of milk. Did they have a cookie party that day? Did everybody drink a lot of milk? Did the dairy not make that delivery that day? I mean, there is a lot of reasons why on two shifts, over however many that witness worked, that they might have run out of milk. But you know, that's not the issue. If it was the issue, believe me, we would have gone out and found out why wasn't there milk that day. It's not the issue. It's designed to do something other than help you decide Joan Boice and the Boice family's plans.

There is so many, you know. I put the word "poop" on there. It comes up over and over again. It's this natural human thing we all do. It's kind of icky. It's the yuck factor. So let's just bring that up every once in a while. Let's bring it up and make the jury uncomfortable. Because we want the jury uncomfortable, I think is the design.

So Dorothy Ting. These people had nothing to do with this case.

Now, I've put up some of the jury instructions here. You are going to find -- the ones on the top are the ones that the judge read to you before we ever started, and the ones down below are the ones that you've heard. And there is a recurring theme more often

in these jury instructions than any other theme in the law that you read, and that is: You must not let bias, sympathy, prejudice, or public opinion influence your decision. You cannot let sympathy, prejudice, public opinion influence your decision. No. That is your duty. That is the oath that you took. And frankly, I submit, ladies and gentlemen, that the weeks and weeks of testimony that we've heard, and the VPQS reports, and all of these things that have nothing to do with Joan Boice are designed to play to that, not -- they don't impact whether the care delivered to Joan Boice was appropriate, or whether it caused her death. It's designed to put you in a frame of -- biased frame of mind.

So what's going on? Why are we doing this? Ladies and gentlemen, I'm telling you, it's a formula. It's the elder-abuse formula, and it starts with a horrible disease of aging. My client and many other providers of long-term care, they provide care in living a life for people who are suffering diseases of aging, that sometimes are going to cause significant challenges for the person. So it's not very hard to find a wonderful, lovely aging person who has developed a bed sore or a fall or whatever the issue is.

You have the helpless plaintiff. Then maybe you have the gory pictures, and the other yuck factors that I talked about. And you know what? Bash the corporation. You will not find a provider of long-term

care that doesn't have some critics out there, some former employees. And in this case, it was dramatic. Remember, Rotella? She testified that Ms. Clement found her because she was looking for people suing Emeritus. She was looking for people suing Emeritus. Well, why would she do that? Because you better believe that those people are going to want to come in and tell a story. She has a lawsuit now against Emeritus. And she didn't work for Emeritus when Joan Boice lived at Emerald Hills. She wasn't even there.

And this is a note to myself. Consider Disneyland. We have -- hopefully we've all had a wonderful time with our children or our siblings or nieces or nephews. It's the happiest place on earth. But I guarantee you that if you wanted to sue Disneyland, and went and searched the court records in Orange County and looked for all the people suing it for either wrongful termination or personal injury, and then you got the incident reports of all the people that stepped off the curb funny or got sick on a hot dog or choked on the popcorn, you can portray Disneyland as a really horrible place. It's not really that hard. And we are not Disneyland. Don't get me wrong, okay? So we have challenges.

Then another part of this formula, the recipe, are these amazingly wonderful, decent care providers, exactly the people that you would want taking care of your loved one at the end of their life. They are

humble, and they are generous, and they are kind-hearted, and patient, and they are loving.

They are not sophisticated. And the last thing they want to do is sit for a deposition. Beyond that, the last thing they want to do is sit for a deposition and be attacked. It's not worth it for them. And I don't blame them. What do you want to know? I'll tell you, and let me go home. They are no -- as wonderful as they are, they are no match for a talented and motivated lawyer. None. And it's part of the formula.

I talked about the motivated critics, the people that are disgruntled employees. Remember the testimony? You'll never find a perfect chart. Never. And if you do, then you probably have some fraud going on. You'll never find a perfect chart. So once we have the plaintiff, we have the patient coming in the door, let's get the chart. Let's not find out if there is an error. Let's find out how many there are.

And here we are in this social model. It's not even a healthcare system.

And then you just allege record fraud, no matter what. If it's a great record, then it has to have been falsified. If it's a horrible record, things must have been pulled out. You can't -- you have one or the other.

Vulnerable defendants. You know, my client is a large corporation, but they are a corporation that provides care to elderly folks. They are no match for a

plaintiff's lawyer that is coming in the back door and investigating and courting sympathetic employees. They are vulnerable. Lisa Hulse. You know, she is no match. She is a nurse.

And then use the company's policies. You know, we heard it this morning. There is an inherent conflict in the theories of the plaintiffs. Is it, you know, do they spit at the law, or do they prepare and support and provide guidance with policies? They have policies. They are great policies. They are available. The corporation wants them to be followed. They provide support.

And so on the one hand, you know, here is this evidence of this company trying to provide guidance and assistance for the communities, and then on the other hand they get beat over their head when the community isn't following it.

They have policies. They have standards that they are shooting for. They are trying to get best practices. But there is always policies, and there's always failure to follow policies.

And then of course we have the marketing materials. These facilities, you know, they need -- there is an interesting obligation here. You've heard about some of the people that apparently weren't happy with Emerald Hills, but by inference there is a lot of people that are, and Emerald Hills has an obligation to those people. They have an obligation to be prudent.

They have an obligation to keep their doors open. They have an obligation to not be wasteful. They have an obligation to be there tomorrow.

And so yes, it's a business. But the business is providing the care. And if they don't do it, they are not going to be successful.

Okay. Then call them understaffed. Okay. Anybody think that if there was one more person working the night shift that we wouldn't be here? Anybody think that if there was two more people working the night shift we wouldn't be here?

It doesn't matter how many staff are there. It's never enough. And here is the interesting thing in this case: I thought there was going to be expert testimony from the plaintiffs' side telling you exactly what they suggested, based on their burden of proof, what the staffing should have been. Well, we didn't hear that testimony. In fact, we didn't hear any testimony about what, under their burden of proof, what the staffing did require. All we heard is Ms. Clement and Dr. Locatell say it wasn't enough, and it needed to be more. Well, it's their burden of proof. How much more? How far short did we fall? In a little while, I'll show you that where we were was at or above the industry standards.

So we call them liars, and we call them cheats, and then we vilify the defense counsel. And I hope, if nothing else in this trial, I have maintained my dignity

and my professionalism and my commitment to the truth. That's my commitment.

So after that, then in comes all of this collateral information to bias you, the VPQS and the incident tracking, and then we beat up the corporation some more, and we play to fear. We heard that: We are all going to be there some day. We are all going to have these needs, and we lead every witness.

What an irony. What an irony in this case. Remember when Dr. Fullerton was on the witness stand, and Ms. Clement says, *Dr. Fullerton, you know, Mr. Reid led you through your testimony*. There were four witnesses in this trial, only four that Ms. Clement was not allowed to ask leading questions. A leading question is one that suggests an answer. So when Ms. Clement stands here and gives you her closing argument over and over again, *right, Doctor, right, Doc,* that's leading questions. And she got to ask leading questions of all but four witnesses, which were her clients. Even those witnesses that sought her out met with her multiple times in her office, helped craft their testimony. She got to lead them. But then on the rare occasion I get to ask leading questions, you know, that's something really evil or horrible or, you know, something to be frowned upon with an expert who I am not going to tell him what to say.

And there is another element here that is so frustrating with leading questions. It's this concept

that if you say it wrong often enough, it can become true. But it doesn't. A wrong statement never becomes a truthful statement, and I want to show you some examples.

How many times did you hear she lost 20 pounds in two and a half months at Emerald Hills? She didn't. She lost 27 pounds over six months, including the seven pounds that she lost the first three weeks at Foothill Oaks. But it gets repeated over and over and over again. And I saw it in some of your questions. *How do you explain this horrific weight loss in just a couple of months?* Well, this was over a long period of time. This was six months, and we've heard why she was losing the weight.

She was not accepted for admission on August 29th. She showed you the regulation. The regulation says before someone is accepted, you have to do certain things, and one of those things is sign a contract. She's beating us up because they did it. They had the family sign the contract.

And they didn't take her money. That was a refundable community fee that actually was paid for her husband. Hers was waived. But you know, that's just the kind of spin that gets tossed into leading questions for a purpose not to arrive at justice.

No preadmission appraisal. You know, we can debate the quality of Peggy Stevenson's evaluation. That's fair. Okay. But we can't ignore that she did

it. Nobody -- nobody -- suggested she didn't do it. In fact, Kathleen Boice was there when she did it. So how come we have heard so many times in this trial there was no preadmission appraisal? It was done. And it was done before she was accepted for admission, because it was going to be Peggy's decision ultimately whether she moved in or not.

No timely physician assessment. You know, that whole thing on 602s, I understand. We have an issue. They didn't comply with the policy. They clearly complied with the law.

No reassessments. Again, there are reassessments. They are the Vigilan reports. They were found in the computer by Doris Marshall. They were printed out by her when she still worked for Emeritus. There was two of them. They weren't signed, because the hard copies that were prepared at the time, we don't know where they are. I'm here with my palms open. I don't know. I don't know. But we found them in the system, and they were done.

No training, no staffing, no supervision. That was specifically quoted in closing argument a little while ago. No staffing, no training, no supervision.

There was staffing. There was training. There was supervision. It existed. They did it. The issue is, did they do it to the level that Ms. Clement suggests it should be done. That's the issue.

No budget. We've seen the budget.

Bedridden. The definition has been misstated in leading questions so many times. It's on the 602 form. You can look at it. It's part of Exhibit 2. But you know, just because Ms. Clement says it's defined as one thing doesn't mean that's the definition, and I don't care how many times she puts it in a question.

Full-time nurse. Okay. That's not what at least the documents said. The documents that you saw that Melissa Gratiot said she would follow and that she would tell the family says a staff nurse available. That's what it says. It doesn't say full-time nurse. I have that coming up a little bit later, so I can give you the exhibit number.

Will not survive the wounds, quote/unquote. Dr. Martin. Do you remember that? Let me show you what Dr. Martin really said. This is a note of December 5th, 2008 by Dr. Martin. What happened is, when Mrs. Boice moved to Foothill Oaks, she then was no longer Dr. Awan's patient. She became Dr. Martin's patient through Kaiser.

On December 5th, Dr. Martin noted "Long discussion with son. Patient's wound may not heal." "Patient's wound may not heal." That's exactly what Dr. Fullerton said. "Patient's wound may not heal." It doesn't say patient will not survive the wound.

And then he says, "Also, more importantly, patient has lost the ability to swallow." "More importantly."

"Encouraged to consider comfort care." And here

is the thing: Remember those roadblocks I told you about? This is number one, first priority. The roadblock that plaintiffs cannot overcome is that ability to swallow, and losing it.

Okay. This ability to swallow was objectively diagnosed first by Dr. Awan, then by Dr. Martin -- the dysphasia -- and by the speech therapist on December 5th at Foothill Oaks.

It is beyond debate that Mrs. Boice lost her ability to swallow. And we know that that is a consequence of Alzheimer's disease and stroke.

Losing the ability to swallow, if you cannot swallow, you are going to lose weight. If you can't swallow, you are going to become malnourished and dehydrated. You are going to fail to thrive. You are go to become significantly at more risk for skin breakdown because your skin is weakening. You don't have the nutrients to protect your skin. And this can't be cured. And not even Dr. Locatell can attribute Ms. Boice's loss of her ability to swallow to poor care at Emerald Hills, okay?

I get it. I heard Dr. Locatell. She -- her skin shouldn't have broken down, and she wouldn't have had contractures. Because if you just do these more things, those won't happen.

What can any person do to another person, or not do, that's going to stop them from being able to swallow? Nothing. It's that loss of the ability to

swallow that stops the plaintiffs' case in its tracks, and that directly led to the death. On the death certificate it was related to the Alzheimer's disease. Certainly it has a stroke component to it as well. It's the stopping point.

So I suggest to you, ladies and gentlemen, that because of that blockade in the road that plaintiffs can't overcome, that's why we spent weeks in trial trying to vilify these people and this company.

So what do we do? We attack. We label -- and I am going to talk about that in a little while. We belittle. We distract. We misstate. We overwhelm. We mislead. We manipulate. We exaggerate. And it's all in the interest of winning. Not in the interest of justice. When a lawyer commits to truth and fairness and justice, then they are not going to be tempted to bully witnesses or spin facts or trick people. But when the purpose is to win, that's when we get a trial like this.

I've I tried a lot of cases. I have amazing respect for my counterparts in this profession. And what I've come to find, ladies and gentlemen of the jury, is that the lawyers with good cases, they don't try to block facts coming in. They welcome them. They are courteous, and they are confident, and they are fair and respectful, and they certainly don't mock people. They don't insult. They don't disparage. They don't need to. They've got a good case. Lets the fact speak

for themselves.

They don't ask every question. Not every question is a leading question. They ask the open-ended questions. They don't waste time. They want to get it done. They don't bring in all of the peripheral stuff, the unnecessary N/A. They don't resort to the histrionics and the drama and the eye-rolling and the exasperation. They don't need to. They've got a good case.

So allow me -- and I want to go through kind of quickly, and I apologize. I've never been able to figure out a way to effectively communicate that lots of care was delivered, and lots of observations were made in contradiction to assertions otherwise, other than to show it. And so I'll move fast, but you need to see this.

In July of 2004, Mrs. Boice executed that durable power of attorney, and she elected the choice not to prolong life.

We heard some testimony about records from Kaiser that didn't get admitted to evidence, but we know that a year before, November of 2006, Mrs. Boice was becoming forgetful. She was watching TV. She stopped paying the bills. She would stare at the front page. She had stopped gardening three years before moving to Emerald Hills. And this was reported by her husband to Dr. Seab.

She had normal strength in the extremities. And

the CT scan we spent a lot of time talking about. He said it shows it might be small strokes -- with or without small strokes -- but it's Alzheimer's disease. And Dr. Fullerton says we are talking about a level 4 or 5 on that scale.

January of 2007, now she's not able to use the ATM. She's having difficulty dressing herself. Eric Boice says it's really been almost like two years since she's been having memory problems. And then the mini mental exam was pretty good. 22 in January of '07.

Now, while at the Palms -- this was interesting, and I have the exhibit numbers up here for you folks. The Palms records are 5001. On page 119, you will see the code/no code page for Ms. Boice that was filled out by her husband. And Mr. Boice, on behalf of his wife, marked the box "Yes" for CPR. He wanted her to be resuscitated.

In December of that year, on page 54 of the same exhibit, now he did a new one, and he checked the box "No." And please, nobody understand me to be judgmental in any fashion about that. Not at all. That is not my intent.

Mrs. Boice had six falls while she lived at the Palms. Two in August of 2007, one in January of '08. She was found by her roommate on the floor. Was that an unwitnessed fall? Is she being supervised?

February of '08, she fell. She's found lying in the living room. She's found lying in the living room.

Ladies and gentlemen, take that formula I gave you and apply it to this. That's a pretty good case. Now, I'm not criticizing the Palms, but I'm saying, when you take all those factors, and you put it to somebody who has fallen six times in less than a year, sure.

The fifth fall was in the parking lot getting out of her husband's car.

Then in May of 2008, she fell and she broke her thumb. A fracture. But the Palms was wonderful, and they had proper staffing, and they properly supervised her, and everything was great. Well, then I guess people that are being properly and adequately supervised in a good, meaningful, supportive environment can fall. Apparently it can happen. It can happen six is times.

February of 2008 is when that e-mail that Eric Boice sent to Dr. Awan confirming "My mother is in advanced stages of her Alzheimer's disease."

Now, Emerald Hills. Before the Boices move in, I want to remind all of you that even though DSS, the Department of Social Services, had switched over to five-year inspections, Emerald Hills' inspection occurred in April of 2008, and here it is. It's Exhibit 222, page 5. It's an unannounced visit. The surveyor, the LPA, reviewed the files. According to Dr. Locatell, she confirmed that when a surveyor surveys a building, they always look at staffing. They always do. And there was no staffing issue.

I just want to encourage all of you, if you decide

to take a look at that 2008 CPR, the one that purports to still have some problems with the Memory Care Unit, take a look at the other section, particularly the pharmacy, the issue that Ms. Hulse was aware of, and the issue that Ms. Hulse got involved in and got her arms around. That 2008 pharmacy CPR is awesome. And it shows great improvement. The issues that Mary Kasuba raised were taken care of by Ms. Hulse and her team because they care, and it matters.

And by the way, the other sections are pretty good, too. I don't know about the memory care one. You heard and you saw Doris Marshall told Lisa Hulse when she was working for Emeritus that she couldn't find it. They were pulling their hair out. And now a despicable company might go back and manufacture it. Look at how great we were in 2008. My client was there going, we wish we had it. We wish we had a lot of things, actually.

All right. Now this wasn't a, you know, get-them-in-the-door-and-close-the-deal type of circumstance with the Boices moving into Emerald Hills. Mr. Boice first toured somewhere in July. If you look at the exhibit, 178, this is all laid out.

And then Eric Boice is talking to Melissa Gratiot in August of 2008. There was a tour. Eric Boice said it's very nice, clean, and friendly staff. And price is going to be the deciding factor, not, wow, we're so impressed with this Join the Journey program, or holy

cow, you know, the website is amazing, and -- it's price. And here it is.

This is what they were told specifically about a nurse: "Licensed nurse on staff to monitor and coordinate care needs." Exhibit 178, page 10. Not a full-time nurse. Not a 24-hour nurse. A licensed nurse on staff.

Then on August 19th there's e-mails back and forth. There is negotiations about how much the rent will be. So there is a lot of horse-trading going on to try to get to the right price so that the Boices can move in.

This is the contract. There was a lot of questions. Remember we looked at the budget, and there was questions about, what are the level-of-care charges? Well, in Exhibit 3, page 28, you can see how that level-of-care charge broke down. It's based on those points. So a level 1 was just 1.25 to 8.75 points, down to a level 6, which was over 53 points.

So when we looked at that budget, and it was only levels 1, 2, and 3, do you remember that? We are talking about people that, you know, had 26 points. And you will see that in Mrs. Boice's Vigilan assessment in September of '08, hers was around 50. So level 3 is half of what Ms. Boice's needs were in September of '08.

I put this signature page up, because here, if there is any question whatsoever, there is the local ombudsman's telephone number. If there is any question,

any concern -- right below Mr. Eric Boice's signature -- here is who you can call and get immediate intervention and relief.

On September 11th, the day before Ms. Boice moved in, you will see in the chart, page 243 of Exhibit 5003, Ms. Kathleen Boice called Dr. Awan's office and asked if Dr. Awan would be willing to double the Seroquel -- remember that medication she started a few months earlier -- in case Mrs. Boice suffers from transfer trauma, which was an appropriate thing. And actually, Dr. Awan did authorize that. Ms. Boice never needed the extra Seroquel.

Ms. Gratiot e-mailed Kathleen Boice, and I think this is very important, frankly, because she says, "Your mom" -- "She still needs to be evaluated by Peggy," okay? This is not a done deal. Melissa Gratiot, on September 11th, is saying, look, she still needs to be seen by Peggy, so she has not been accepted for admission. She hasn't.

Then Emerald Hills -- I think it was Lynda Kittle -- faxed to Dr. Awan, on the 11th, a list of medications, and she said, "It's urgent. The resident will not be permitted to move in unless the doctor authorizes these medications." So there was a lot of things, even as of September 11th, that had to happen.

On the 12th she was accepted after she was evaluated by Peggy Stevenson. And the doctor was involved, and the family was involved, and an assessment

was done, and we heard from staff that were all involved in that.

And she was appropriate for admission. She was not bedridden. There is the definition of bedridden that had been misstated so many times in this trial, and I'll let you all look at that later.

You saw the regulation that says that the 602 can be up to a year old. It's not in compliance with the policy, the gold standard, that's true. But it's certainly not in violation of the regulations either.

A prohibited condition is one who is dependent on others to perform all activities -- dependent for all activities of daily living. That gets misstated all the time, too. She was not completely dependent for all ADLs, according to the assessment by Peggy, with Kathleen Boice next to her.

And Ms. Kathleen Boice did fill out that biosketch family document -- it's three or four pages long -- on September 12th, so there was input from the family as well as in terms of who Mrs. Boice is. And you heard this goes in the notebook for the care staff to see. It's in the medication room.

Then on the 16th you will see in the records that Melissa Gratiot e-mailed Eric Boice and said, *hey look, you know those documents, those additional documents I gave you? We need those back. I gave you a notebook last week, but we need them back*, and he wrote back and said he would be in tomorrow. That's Exhibit 3, pages

38.

All right. Now, those are the documents that had some really key advisories in it, okay? And we start to talk about fraud.

The first one is a disclosure regarding fall risk signed purportedly by Eric Boice, but we come to find out in trial it was actually signed by his wife while they sat side by side. And it says, "The family acknowledges that the intimate relationship between the resident and the resident's family is a critical element of identifying these symptoms. The community staff requests the family report immediately to the community different changes in appetite, balance, weight and skin conditions," right?

Now, yeah. That makes sense. Myron Boice is visiting his wife every day. Eric and Kathleen are coming in all the time. You know, if there is this dramatic weight loss, aren't they noticing it? I mean, they are the family.

And then the one I read to you quite a bit in opening statement, the statement of informed choice, which is really a compelling document, and a real true effort to try to put out there, here is what we can do and here is what we can't do: "The community does not provide one-on-one 24-hour nursing care."

"Mental and physical conditions change, and assisted living may cease to be a viable living option."

"Unfortunately, the aging process can lead to loss

of skin integrity." This is Exhibit 3, pages 68 and 69, signed purportedly by Eric Boice, but by his wife.

They also gave the Ethics First hotline number to the Boice family in that package.

They also gave this Assisted Living Consumer Disclosure Statement, several pages long, and it's prepared by one of the trade groups, and it's approved by the Community Care Licensing Division.

There is a lot of disclosure going on in these documents.

The fall on September 22nd I contend was very appropriately handled by the staff. They got her to the hospital. We saw the testimony yesterday. She hit her head. She goes to the hospital.

I really thought it was interesting, you know, when Lynda Kittle was being interrogated in deposition, and she was basically forced to admit, yeah, I guess I should have reported that to the doctor, this caregiver, when it's the healthcare providers that are going to communicate.

You will see -- we've seen these documents. You see Dr. Stamper says "Kaiser has been notified."

Then here is Lynda Kittle again, faxing. She did reach out to Dr. Awan, and did let Dr. Awan know about the fall. And you know, she was on top of it.

The September 30th Vigilan evaluation is Exhibit 68, and Mrs. Boice's score was 47 and a quarter. That's Exhibit 68. And she was, at that time, noted to

be a one-person assist. There is the document.

On October 1st through the 13th -- these are interesting documents here in Exhibit 5003. There is this effort by Emerald Hills to try to get the whole pharmacy set up, and back-and-forth communications about getting -- they need to get a hard copy of her prescription from a pharmacy in Sacramento, and it goes on and on. And then it's determined that there is quite a bit of morphine left, so we don't need it right now.

Then on the 14th we know very well the facts from Nanette about the problems with her putting weight on her right foot. And you know, there is no documentation that the family was notified. There isn't. They were there every day. They must have made the same observations that Nanette made, but there is no documentation. But we do know that Ms. Boice was back seeing Dr. Awan within a couple of weeks of the fracture, and no x-ray was done.

There is the fax.

Now, I think -- I think this is a really helpful slide, because when we have people that are engaging with Mrs. Boice every day, maybe it gets hard to see those changes. They are subtle changes, you know, and how do you know that someone has had a subtle change from yesterday from today or today to tomorrow? Maybe the changes are happening, and they are not so apparent to someone that is intimately familiar with a patient or a resident.

So it occurred to me, well, let's use Dr. Awan as our milepost, our mile markers, okay? So Exhibit 5003, pages 88 and 89, that's Dr. Awan's March 2007 assessment. Okay. And I used a little bit of the information from Dr. Seab, too, who saw Ms. Boice just before that.

You look at those documents. They weighed her that day, and she weighed 150 pounds. I don't know about the Palms records, but the Kaiser records say she weighed 150 pounds, and they show that she was weighed that day in the office.

We talked about those notes. She needs help with dressing. There is no eating or swallowing problems. Remember, comfort is primary now, and Dr. Fullerton says Alzheimer's stage 4 to 5. Okay. So that's March of 2007.

So let's take what Dr. Awan sees in June of 2008. That's the same exhibit, 5003, pages 227 to 230. They weighed her that day, and her weight was 137 pounds. So if you believe the Kaiser records, in 15 months she dropped 13 pounds.

Go back to the formula. Six falls, 13 pounds. You know. Records that aren't going to be complete. Employees that aren't going to be happy. You have the makings. Again, I am not criticizing them, because I think we can see what is happening.

Her dementia is steadily getting worse. She's now wandering at night, and becoming combative, and they

start her on the Seroquel. She is walking with a walker, and now needs cues to eat and swallow.

So what in the world did the Palms staff do to cause her to not be able to eat as well? What did they do to prevent her from being able to swallow her food? Nothing. So apparently, in the context of outstanding great care, a patient, a resident like Mrs. Boice can start to become -- have trouble eating and swallowing. And Dr. Fullerton says now we are talking Alzheimer's stages 6 to 7.

Okay. So compare June of 2008 to November of 2008. That's the same exhibit, pages 282, 285. We looked at the November '08 note multiple times. But isn't it interesting, when you put it next to Dr. Awan's other observations? And we use Dr. Awan as our mile markers. What's Dr. Awan seeing now?

First of all, they didn't weigh her, so that's interesting. I guess Dr. Awan or her staff wasn't that particularly concerned about her weight at that time, because obviously if the doctor looks at someone and thinks, holy cow, you are losing a ton of weight, they are going to weigh her, but they didn't weigh her.

It's reported she's had mobility problems the last two or three months. She cannot stand or bear weight on the right, and she has no movement of her right leg. Her right arm and hand have little movement.

And don't -- Dr. Awan, she said it. She thought it was strokes. And I thought -- and she also notes the

swallowing problems, pocketing food. She had food in her mouth at that time.

So the swallowing problem is very apparent and very problematic, and can't possibly be caused by my clients. It can't.

I thought it was so interesting with Dr. Awan when -- I called Dr. Awan. I called Mrs. Boice's treating physician to the witness stand. In a trial where plaintiffs are suing my client about Joan Boice's care, I have to call the treating physician in my case in chief. Dr. Awan, she is a lovely lady. She was very impressive. And when I was questioning her, she was engaged and articulate, and she knew her stuff. And then when Ms. Clement got up, she was like a different person. I don't know if you noticed that. I did. She was reserved. She didn't want to talk, and she was, you know, peppered with leading questions. *So are you just guessing or that's where that came from?* She said her opinion was at that time, yes, this was strokes. She said it.

And Dr. Fullerton says, okay, swallowing problems. The lack of mobility. She's hospice eligible. Dr. Awan said it too in this context.

I am just going to move past this. So I am going to move through these fast. You've seen these records, but this where you see the incredible bulk of care that's being delivered to Joan Boice while she's living at Emerald Hills by her healthcare providers.

It starts on the 6th. It's a one-hour physical therapy evaluation. And as you go through these -- this is Exhibit 5005, 74 to 84. It's multiple pages.

The physical therapist is talking about recent CVA, cardiovascular accident, cerebrovascular accident. That's a stroke. At that time, little or no recovery is expected, and further decline is imminent.

And training for caregivers for fall and safety prevention, transfers, training, passive range of motion exercises, positioning for skin protection, and edema control. The staff is getting trained by the physical therapist on November 6th. You know who was there? Eric Boice was there, too. He was part of it. Very involved. There is the note. And Alicia was part of it, too.

Now, remember how there was that problem with the morphine on November 4th? Well, it turns out that as of November 11 -- and this dates back to the stuff that was going on in October -- on the 11th, Emerald Hills is starting a fax saying, we're running out, we need a morphine order. And you will see it in the chart on page 47 of Exhibit 2. So it wasn't like they just ran out and somebody said, hey, you know, what's going on? They were working trying to get that morphine filled.

November 12th. The physical therapist came out for a follow-up visit, and now we have the physical therapist, Kim.

Here is that fax I was telling you about on

November 11th, and Kim Chaney's note as well.

So on the 14th we've got all these efforts to get the morphine filled. We have the physical therapist coming back. And this is when it's noted that the bunion is now -- has some discharge, and the physical therapist instructs the caregivers on pressure relief, and applying a clean, dry cover to the wound, and there is coordination of the care.

And Dr. Awan orders Misty to get involved on November 14th. This is notes regarding getting the prescription filled. This is Mr. Chaney's note. That's the order for the medical social work, and the date involved that date, the 14th. All right.

So the 17th we have the family meeting at Emerald Hills.

The 18th we have the skilled nursing evaluation. They are free-lifting her into bed. The med techs will provide daily care, which is washing with saline, applying an ointment, and putting a bandage. They are training the -- the nurse trains the med techs on that. And the nurse then determines how often she is going to come back, and gets the doctor to order it.

Then we start to get into the e-mails back and forth between Kathleen Boice and the Boice family and Emerald Hills. And this a follow-up to the meeting. 5015 is the exhibit, and you can follow those along.

So I just wanted to show you. Here is the bedside training. More bedside training re: care, pressure

relief and safety. And I'll suggest to you, ladies and gentlemen, and I'll say it now, there is no way -- there is no way this woman had a big wound on her rear end. Just think about that. We've got nurses coming in, physical therapists coming in and family coming in, and there would be no motivation to not tell them about it. I mean, it doesn't make any sense. What makes sense is either Jenny Hitt had a different motive, or she's confused about when she started to get involved in these things.

All right. November 19th. Lots going on. The social worker is getting involved. Her notes are in 5005. We've got the skilled nursing out. No pain, does the treatment, and she has discussions with Peggy and Nancy and Misty about hospice. And here is what I think is interesting: So Ms. Stevenson doesn't remember Mrs. Boice. She doesn't. She doesn't remember anything she does for Mrs. Boice. But you know what? The Kaiser records show that she was involved. She was coordinating the care. So you know, Peggy Stevenson, she has no dog in this fight. There is no motivation for her to come in here and lie, and if she was going to lie, wouldn't she at least come up with some recollections? She didn't have it.

We have more e-mail communications back and forth.

Nancy Cordova. We are glad you are involved in the care. Home health here now. And Kathleen Boice says, yeah, Misty called me. We are going to pursue

hospice. That's the 19th. Misty has detailed notes, and we've seen them.

This is that document that Misty did on the 19th where she initiates the skilled nursing referral, which goes back and forth. It gets filed a bunch of times.

And then here is the note about coordinating with Peggy and Nancy. And Peggy on this date gets similar instruction about what to watch for with the wound as the med techs had already gotten.

November 20th. The physical therapist is back in the building. He notes, "Caregivers are independent with active range of motion and passive range of motion exercises to maintain all extremities."

Misty is involved. They are still talking about hospice. The Department of Social Services says hospice will be fine. And then Nancy Cordova tells Kathleen Boice, "I supervised some training the physical therapist did with the caregivers, the resident attendants, mostly range of motion and repositioning, and Joan Boice was smiling and participating."

That doesn't sound like neglectful, inattentive, horrific, abusive care. It sounds like very attentive care and coordinated care.

November 21st. Another skilled nursing follow-up. You will see on that document, Exhibit 5005, she's tolerating her treatment well. She tolerated the procedure well. Misty, on that date, is informed by Peggy that the corporate office declined continued care

due to the stage 3 wounds, even if hospice is in place, and Peggy told her she told Kathleen Boice that. That's the opposite of "closing the back door."

And remember this? Misty phoned Kathleen Boice and updated her on Emerald Hills', quote, decision and need for placement versus hospice at this time.

So November 21st, we are all now, including the Boice family, on the path for skilled nursing placement. November 21st. That's Exhibit 5005, page 104.

November 24th. "We have the physical therapist back in. Patient appears comfortable. Caregivers give general stretching, repositioning and pressure relief." We've got Misty faxing, finding out what's going on with the doctor order.

Now we have notes by elder care. "EC" is the Kaiser elder care folks. And I'll show that you in a minute. That's easy because it's Exhibit 5006. It's all on two pages, 9 and 10.

And the elder care people are the ones that are responsible for getting the order, and coordinating the placement, the transfer to the skilled nurse facility. So the elder care department says, "We can't locate the doctor's number. We'll check to see if the orders made it to the M.D. inbox tomorrow."

And it's November 24th that the second Vigilan, the third assessment, the second Vigilan assessment, takes place. Now she's 100.5 points. So she's more than doubled in her needs. Of course, there is effort

underway to get her placed in a skilled nursing facility, and we have Kaiser coming with in nurses and physical therapists to take care of her while this process is going on. As you see, she's 90 minutes that she needs with dressing and undressing, and she is a two-person assist with transfers. Now she is a two-person assist.

Here is a note from physical therapy. Once again, Kim Chaney is saying, "Instructed the caregivers regarding proper positioning for movement and pressure relief. Patient appears comfortable."

At the bottom are the notes from the elder care folks. It's 5006, 9 and 10.

On November 24th, "RCFE will not keep the patient per Misty. Sent order forms to Dr. Awan. They were unable to locate" is what I told you about. And there is the Vigilan assessment. There is the two-person assist.

November 25th, 45-minute skilled nursing follow-up. "Patient denies pain. Wound responding to treatment" according to Mary Ransbury, and the care is being provided pursuant to the doctor's orders.

On that same day, we have elder care faxing to Foothill Oaks. "They say they will take her, but they have to have an available bed." And "Misty is going to call the doctor to urge getting the order for transfer."

5005 is again the home health nurse notes, and 5006 is the elder care.

So on November 28th, we have a 45-minute follow-up with skilled nursing. "The patient denied pain. Tolerated wound care without signs or symptoms of pain. The wound is granulating well," which is what Mary Ransbury told you about. That's a positive sign. That means that whoever is taking care of that wound is doing a good job. They are doing what they are supposed to do. If they were in a home, anybody can do it.

Kaiser elder care is still waiting for the SNF order from the doctor, and they refaxed to the doctor the order to transfer to the skilled nursing.

November 30th. The care alert comes out. And that's the same day that Kathleen Boice e-mails Nancy Cordova and says, "I heard nothing from the social workers this week," and I think that's when she said, "I think maybe it fell through the cracks." Oh, no, that's down at the bottom. That's on the 1st. She didn't hear from the social workers.

Then on the 1st we have a lot of activity because that's when the new wounds are identified. We have skilled nursing providing care and instructing the staff. We have the social worker saying, look, we need this order. Kathleen Boice is updated. Elder care department is still awaiting the doctor's order.

Peggy Stevenson. That's the date Peggy e-mailed Kathleen Boice and, you know, mentioned, look, there is more skin issues here. And on that date, Misty also talked to Kathleen. It was that day when Kathleen Boice

wrote back and said, "I think this whole idea of getting her moved fell through the cracks at Kaiser because of the holiday."

When you put it all into context, you can understand why she would say that. Because it's been ten days since the -- about eight, ten days since the decision to go to skilled nursing, and they've been waiting for the doctor's order. In the meantime, Kaiser is in -- she's getting care. They are taking care of the wound. She is doing okay. They are just kind of, you know, trying to work together to move her to the next facility.

There is the care alert we've seen.

You see down at the bottom, "Still awaiting doctor's orders." These little notes here are the elder care department, and then this is the social worker, Misty's, note that they are still waiting for the order.

On December 2nd, the physical therapist is back in. He notes no pain. "Patient appears comfortable in bed. Teaching is done so the caregivers" -- "with caregivers are independent with the range of motion and protecting the patient from skin breakdown."

Do you hear a recurring theme? Every time Kaiser is in there, they are talking to the staff and saying, you need to do this, you need to do that. Obviously they are being trained. And when we saw the regulations, it talked about bedside training, and specific training to the resident.

Elder care note that day. They need the order for the SNF. She can't say at the assisted living. They even offered to help fill out the forms. And then they got the order. Then they call Foothill Oaks, and Foothill Oaks said, you know, I remember the name, but I need to find the referral. And we don't have a bed today, so maybe tomorrow.

Teaching regarding pressure relief to bony areas with the staff by Kim Chaney on December 1st.

Here is the note about Foothill Oaks. They need to find the referral.

On the 3rd, they resend the referral to Foothill Oaks. Emerald Hills on this date faxes Dr. Awan and says -- and asks for an order to crush her medications. I'll show you that in a second.

Foothill Oaks no longer has the referral. They refaxed it. They had confused Joan Boice with another patient, so they need the referral again.

The social worker contacted elder care and Kathleen Boice and the home health to coordinate the placement. And I'll show you the order -- the request for an order from Lynda Kittle. "Your patient, Joan Boice, has much difficulty swallowing medication. We need an order to crush her medications, and can we get liquid morphine sulfate."

December 4th is when she moved. And this is really interesting. It was on December 4th that the elder care department ordered a low-air-loss mattress to

be delivered to Foothill Oaks. Remember Mary Ransbury? She said low-air-loss mattress. That's an intervention that can be used to try to minimize skin breakdown. And it was when she moved to Foothill Oaks that Kaiser got her a low-air-loss mattress, and she was on a low-air-loss mattress at Kaiser. And that's going to help minimize skin breakdown.

Then remember that note from Alicia Parga? I'll show that you in a second.

Here is the elder care note. "Called Charlie to order low-air-loss mattress," and she confirmed that it was delivered to Foothill Oaks.

So from December 4th on, Ms. Boice is on a mattress that is designed to relieve pressure to her body and to minimize skin problems.

And here is Alicia's note to Benny about "Joan can express pain by moaning or frowning. She can be resistive to change slightly, but responds well when you make her laugh. She is dependent with eating and drinking fluids. She also pockets food."

You know, like I said, with all of this going on, our staff knows not only that getting Joan to laugh helps them deliver care, but that they can make her laugh and be part of her life. And remember Alicia Parga? She would sit at her bedside and rub lotion. That's what this about. So Emerald Hills had -- the Emerald Hills staff, they were the right people at the right time.

You met Nancy Cordova. She is an amazing person. I suggest to you, all of these people are amazing in their own way. Master's degree in geriatrics. She used to work at Sunrise. There is no way she is going to -- she is not going to understand what hospice is. She sold hospice for two years before she came to Emerald Hills. She knows what it means. And boy, we saw her heart. That's what's amazing about this process, is when somebody opens up like that, and we get to see who they really are.

And Peggy Stevenson. She had been a nurse a long time. And you know, she's gotten beat up pretty good in this trial, but what we heard is that she was a positive force at Emerald Hills. She got systems working better. Remember how much Alicia appreciated having her there? She really improved morale. And this woman had absolutely no motivation to come in here and lie. What it was is, she is one of those people that recognized that when they just go in naively and innocently, and think I am just going to tell the truth, they can get really, really, really beat up in trial or in deposition. And she didn't want to go through that at trial.

Let's talk about the staff themselves. And we've both talked about Ms. Reuther. Ms. Reuther is not a real friend of ours or mine. But you know, she says they were good girls, and they worked hard.

Jenny, Michelle, Heather, Nanette seemed dedicated

to taking care of the residents. I think they cared greatly. The staff would come into her room and spend an hour with Joan Boice, moving her, rolling her, getting her in the wheelchair, taking her to meals. There is our insight into the attention and the care that was being delivered to Joan Boice.

Lynda Kittle remembered Joan Boice. Lynda, what a nice person, you know? You can tell how caring she is. She remembered Joan as a nice lady, very pleasant. She had difficulty during meal time, and she observed pocketing. And I suggest, ladies and gentlemen of the jury, that the only way you can know if somebody is pocketing food is if they are getting food in their mouth. Whether they are doing it themselves or someone is helping them do it, food is getting into Joan Boice's mouth, because it's winding up in her cheek.

So this isn't a matter of somebody ignoring Joan Boice, that they put the plate down, and if she doesn't eat it, too bad. She would move her side to side every hour, prop pillows between her knees. She asked for the order to crush the medications.

Alicia Parga remembered Joan Boice as sweet and quiet. She remembered her husband visited every day. Joan Boice would mimic the eating. And she needed assistance. And she testified that as Joan's condition got worse, she would sit by her bed, and she would read to her, play classical music, talk about family photos, reminisce about Disneyland. That's awesome. And then,

you know, then in closing argument, I just thought, so was she this poor, sweet gal who is really caring and decent and in over her head, or is she a lying, unqualified abuser of the elderly that is neglecting and ignoring the needs of Joan Boice? Which is it? You can't have it both ways. These are the people that are delivering the care.

Staffing. We had an average census of 17 people in the Memory Care Unit, and an average of 7 caregivers assigned per day, with an average of 12 additional caregivers in the assisted living.

You saw the budget, the total budget. You know, I put the total number up there. It was 230 hours a day of people working in Emerald Hills. I put the whole number, because we get this impression of, you know, crickets. There is a lot of people, and a lot of activity going on at Emerald Hills, and what we find out through your questions is that Emerald Hills staffing was the same or higher than it was at Aegis where Dr. Fullerton is the medical director. He said they had two memory care units, twice as many dementia residents, and they -- and their building was twice the size, and they had two people working at night. And they charged a lot more, too.

So it puts into perspective, it puts into context what we are talking about. And it's not -- at the end of the day, it's not me that decides what the proper staffing level is, and it's not Ms. Clement. It's

actually you, but based on the testimony you heard. And I am going to talk about that in a minute.

Here we have -- I want you to take a look at those TDR ares, the time records. It turns out that most of those dates where we didn't have somebody clocking in to work in memory care, most of those dates Mr. Arriaga worked in the AL side. So what a great guy he was, and he always confirmed somebody was there. So if somebody got misclassified, there is no question somebody was working in AL. Somebody was there. And Mr. Arriaga confirms that for us.

The state's requirements were well exceeded. Here is what the requirement is: "In facilities caring for 16 to 100 residents, at least one employee shall be on duty on the premises awake, and another employee shall be on call and capable of responding in ten minutes." That's what we are talking about, okay? That's the framework we are talking about. And then if you have another 100 residents, you have to have one additional staff person awake.

Now, granted, we have to account for acuity needs. But plaintiffs didn't offer any evidence about what we were supposed to have to meet the standard of care. It just wasn't enough, and in the context of two people taking care of 200 people, is at least a floor.

So the ladies that we were talking about, the caregivers at Emerald Hills -- and I apologize for all the words up there; that's not how you are supposed to

use PowerPoint -- but as Ms. Clement talked, I had to keep adding. They were there for her, and they did have training.

Look at Exhibit 32. Ms. Clement points out three sentences out of a 200-page exhibit. There is a tremendous amount of training going on. Is it in exact compliance with the state regulations? It's hard to know. But it's not that they are not training. There is a lot of training, and you are welcome to look at it. These people are not being, you know, thrown to the wolves.

Nancy Cordova was running training. If she didn't have her systems specifically in place to make sure they covered every topic, I don't know. Maybe they did. Mr. Arriaga said the Join the Journey, *I had it twice. Once when I started, and two years later.* We don't have the record. He testified to it. Is he a liar?

They have the time they needed to do the things they needed to do. Susan Ruether told us that. They treated her bunions successfully with putting the saline and the gel and the bandage. It got better. And they prevented all these things that Ms. Boice was at risk for.

That's where we start to understand that they were doing a good job. It would have been obvious to these Kaiser folks who go into homes to take care of people. It would have been obvious if they weren't doing their job. And not only would it have been obvious, but the

Kaiser people would have been obligated to do something about it.

It's the plaintiffs who have the significant burden of proof to prove their case, and they haven't offered any evidence of anyone coming in and saying, you know, I saw Ms. Boice being mistreated. I saw Ms. Boice.

Everybody that came in loved Ms. Boice. Jenny Hitt, no friend of mine, she came in, and she took care of Ms. Boice. Everybody was helping her from the testimony. Now, maybe they might say well, I took care of her, but I don't think Alicia did. But when you put it all together, the testimony supports people really pulling together and helping Ms. Boice.

You can't -- she can't have it both ways. They are the boots on the ground. They are the ones that are providing the care or not. They are the ones making sure she's getting food or not. They are the ones repositioning her or not. They can't be recklessly neglectful and ignoring Ms. Boice while being wonderful, caring, decent people. And it's clear that they were wonderful, caring, decent people. I agree. But that's because they were taking care of Ms. Boice. They were providing the care that she needed while everybody was working together to try to move her to her next home.

So when you look at the jury instructions, and it says, do what reasonable people would do in the same or similar circumstances, that's what Dr. Fullerton was

saying. Look, there is no regulation, there is no policy and procedure that says when you have someone who is in a terminal decline, and the family wants hospice, and Kaiser is trying to get the order, there is no recipe. Do what's right for the resident. Do what's reasonable under the circumstance. And they did it. They did it. And it takes this amount of work, and this amount of effort and evaluation and analysis, and this amount of digging in to understand it. But it was done.

The tragedy is the vicious allegations. It's not the care. And I put there -- something is rocking the projector -- but do you think that Nanette Read felt appreciated by Ms. Clement or Lynda Kittle or those other caregivers? She's sitting here complimenting them and saying how nice they are. Alicia Parga is crying her eyes out. That's not how you get to justice. That's not how you get to the truth.

Those were days that those caregivers I suggest would like to forget forever, those days of deposition, and those days in trial. They are simple people who take care of people, and it's not fair, and it's not right.

Foothill Oaks, real quick. We didn't get very far into these records, but there is some really important stuff here folks.

First all, I showed you, she has the pressure-relieving mattress. She is on a pressure-relieving device now. She's getting

comfort/palliative care. She continues to have the swallowing problems and the weight loss. And what I am going to show you in a minute is note after note after note after note of the palliative treatment working. No signs and symptoms of pain or distress.

And she still has -- her skin is very fragile. There is a request for arm guards in the middle of December. And the nurse's notes document family visits.

So take a look at 5002, pages 285 through 319. They are the nurse's notes for Foothill Oaks. The nurse notes, "Family at bedside" on December 4th when Ms. Boice moved in. And the nurse notes, "Family at bedside" on December 17th, 2008, page 292.

Ladies and gentlemen, December 17th, 2008 is the date that the plaintiffs told us in written discovery more than two years ago that those wound photos were taken. Remember? They gave us about 20 pictures with a verified response saying, *Here is the pictures we took an December 17th*, and that's what we understood for two and a half years, until last October, this past October, after we took the deposition of Dr. Locatell, and said, *Dr. Locatell, how can you rely on these pictures? They were taken two weeks after she was moved to Foothill Oaks.* Well, guess what? Then we get an amended response that says no, no, no, no, those pictures were taken on December 8th. Well, the nurses don't document any visit on December 8th. They do document a visit on the 17th, the day that, for two and a half years or so,

we understood the pictures had been taken.

On December 19th, Mr. Boice is noted to be at the bedside.

On December 27th, two days after Christmas, the patient's son is at the bedside.

On December 30th -- see? Even bad things happen in nursing homes. Ms. Boice had a fall. Her head got stuck in the bed rails. She got a skin tear and some wounds on her body, and Eric Boice came in to check on her.

January 18th, it says "Family at bedside" in the nurse's notes.

January 22nd, "Daughter at bedside."

And February 12th, "Son visited." Not on February 11th, but February 12th.

And those are all of the notes of visits in the nurse's notes. Here is -- I just cut and pasted. You are welcome to go through those nurses notes.

"No expression of pain. No signs and symptoms of pain or discomfort." Here is the request for arm guards. "Denies pain. Pain meds given. No complaints. No signs of discomfort. No signs and symptoms of pain."

It goes on and on and on. That's what palliative care at end of life in a terminal decline is all about, is keeping someone comfortable, and it worked. Thank God it worked.

So I have never, ever, ever suggested -- well, I take that back. I did it make one suggestion. I am not

suggesting that mandated reporters failed to report suspected neglect. What I'm suggesting is that dozens of mandated reporters who are required to report suspected neglect didn't, because there wasn't neglect. Not one of them.

And look here: This is a misdemeanor. If a mandated reporter suspects neglect and doesn't report it, it's a misdemeanor.

Dr. Locatell -- and she's the one that I suggested did perhaps not comply with this, because she told us when she saw the wounds, when she saw the wound on the ischium, she knew that that was neglect, but she didn't call. She didn't report.

Here is the list of mandated reporters that I could find who didn't report suspected neglect. There is -- I didn't count them -- 13, 14 from Kaiser, and probably almost double of that at Foothill Oaks. And I only went to the early notes. I didn't go into January and February. I'm looking at early December.

Because if you have familiarity with the nursing home, first of all we have Dr. Martin and Benny Gee, the admitting nurse. We have a physical therapist, a speech therapist, an occupational therapist, and a wound nurse. We have this MDS, which is this entire assessment process. Director of staff development, a social worker, a dietician, and multiple, multiple charges nurse.

And you know, there is a nurse on every shift.

And none of them, not one of them, picked up the phone to call and report suspected neglect. That is powerful, powerful evidence by people smarter than me and, pardon me, but with more experience and training than all of us here who know what neglect looks like and what it doesn't look like, and it doesn't look like this.

And I had, at the bottom, Kathryn Locatell. She didn't report suspected neglect.

In those jury instructions that the judge read to you, in forming your opinion -- I wanted to point this out. In determining whether the standard of care was met, you have to make your opinion based only on the testimony you heard in this case. That is really, really important. What that means is, that since I don't know how to run an assisted-living community, and you all don't know how to run an assisted-living community, you are not in a position to substitute your judgment for what the witnesses have told you should happen. You can't -- your duty does not allow you to say, well, I don't care what Dr. Fullerton says. I don't care what Dr. Locatell says. I think it should be like this. That violates your oath. You have to -- you have to be guided by the testimony. You can't substitute your own judgment, okay? And that's really, really important, because a lot of this emotional testimony is designed to inflame, and have you say, whoa, I don't care what the law says. There should be a lot more people working in these facilities. You can't

do that. You have to base your judgment, your verdict, on what you've heard.

And just very quickly, Mary Ransbury, the nursing expert, she loves -- she has a passion for wounds. She was unrebutted.

Dr. Tindall. He was unrebutted. That poor guy. All he did was come in and testify -- he's a neurologist, and he been one for 40 years, and he wanted to share why he knows that Ms. Boice had strokes. That's all. He didn't offer -- he didn't offer opinions about whether he thought the care was appropriate or not. I didn't ask him anything -- any of those questions. He came up here and wanted to share with you what he knows about neurology, and the next thing you know, he's getting beat up about opinions that he never testified to.

It's called the straw man, and it's a technique that lawyers use: Don't ask people about things they know about. Ask people about the things they don't know about. That's not fair. No wonder he was so frustrated. He just wanted to tell you what strokes are, and how they happen, and how after 40 years of experience having been a medical director of a rehabilitation hospital for years and years, why you all should know about Ms. Boice's strokes, and he has to stay overnight and come back the next day and just get berated. That is not justice.

And Dr. Fullerton, his is the only resume that's

been admitted into evidence, Exhibit 425. Take a look at it. There is another example. I didn't ask Dr. Fullerton about Physician of the Year. I mean, it didn't even come up. But Ms. Clement goes deep into his resume, pulls something out, and tries to impeach him with it when, you know, why? I'll tell you why: She has to do something. She can't let him sit up there and tell the truth and hurt her case, so she has to try to find some way to attack him, and that's a pretty weak way.

Take a look at his resume, and then ask yourself this: When you compare Dr. Fullerton to Dr. Locatell -- remember, we've had court reporters here this whole time. Who has more to lose to come in here and offer opinions that aren't valid, okay? Dr. Fullerton is board certified by the Board of Hospice and Palliative Medicine. He is board certified by geriatrics. He is board certified with medical directors. He has half a dozen boards. And do you think he is going to come in here and put his reputation on the line with his testimony being recorded, with all that he has going on, and all he has at stake, to lie for Emerald Hills? No.

Now, Dr. Locatell, who has one patient, and basically one attorney-client who she has reviewed cases for solidly since 1997, I think it was, has looked at -- she's like an in-house expert. Dr. Locatell is not going to lose her job by coming in here and testifying to what Ms. Clement wants her to say. And she is not

going to lose her job with the government. Her job with the government is testifying against, you know, nursing homes and long-term-care providers. So just, again, we have doctors coming in here with their training and their experience telling you what they understand and sharing with you the truth.

I am going to start with the end of the verdict forms, and then work backwards.

THE COURT: Mr. Reid, we've been going about two hours now. Best estimate for concluding?

MR. REID: Probably 15 minutes.

THE COURT: That a firm 15 minutes?

MR. REID: I'll talk faster.

THE COURT: Ladies and gentlemen of the jury, let's take our break. Leave your notebooks on the chairs. Remember the admonitions.

Please allow the jurors to leave.

All right. We are in recess.

[Recess.]

[Court Reporter switch.]

(The following proceedings were held in open court, in the presence of the jury:)

COURT ATTENDANT: Come to order. Department 45 is once again in session. You may be seated.

MR. REID: Thank you, your Honor.

I needed some water. That was good timing for a break.

So I wanted to start at the end of the verdict forms first. I think what is going to happen is as you -- as you do your job as jurors and you apply the law to the evidence and the facts, I don't think you are going to find yourself at these parts of the verdict forms, but if you do, I just wanted to have -- remind you of a few things.

First of all, it's the Plaintiffs' burden of proof on all issues, okay. And it's either preponderance of the evidence or, I mean, more likely than not, or clear and convincing evidence. We will see that. Damages cannot be speculative, and, um, the causal connection there has to be a substantial factor. I'll show you that in a second.

You have to use calm and reasoned judgment. And that's -- I want to make sure that I made that point clear because there is -- there is this intensity that's created in a trial, particularly one of this length and of these dynamics. And I think it's intentionally designed to create something that is not calm and reasoned. And you cannot punish. This is not about punishment. So, um, finally, what -- what the attorney says or thinks is not relevant to your deliberation.

Ms. Clement hasn't told you what she thinks you should award her clients. I'm sure she will probably -- she may mention that in the next time she is up. Just bear in mind that these are not facts, in my estimation, that warrant a substantial shift of wealth, um, to the Boice family. Their loss is -- is true. They lost their mother. They lost their mother to a disease, not to a company. Not to people that were doing battle with the disease.

So some of the jury instructions that you have and you've seen, there is no fixed standard. You must use your judgment and decide a reasonable amount and use your common sense. That's what's wonderful about this system is a collective common sense. You cannot include as part of your award any amount for attorneys fees or expenses, okay. Those are not included in any award that you would make, should you find yourself at that part of any of the forms. This is really important.

Now, this -- this middle section deals with that wrongful death claim. In considering damages, should you find -- and I think there is going to be a significant blockade there -- but if you are considering contemplating an award for wrongful death, you cannot award for grief, sorrow or mental anguish for these folks. Why is that?

Grief, sorrow, mental anguish, because the law recognizes that in our circle of life we are going to lose people we love and the Boices were going to lose -- lose -- these folks were going to lose their mother and they were going to lose their father as we all will. It's hard to

think about. Some day we are all going to suffer that grief, sorrow and anguish.

And whether you decide that because of something Emerald Hills did and was a day early or a year early, that -- they were going to experience that. And any argument to you about grief, sorrow or mental anguish that those folks suffered is not proper and it would be designed for a different purpose than justice. It would be designed, I submit, and would go into the NA category.

And you will not be awarding any punitive damages. Nothing to punish. Nothing to punish in either of these verdict forms. That is not part of your duty. And I wrote this note down at the bottom. It is not pay-back time. That is inappropriate argument and inappropriate suggestion to you folks and that is not your job at all. Pay-back time. Pay-back time is punishment. Pay-back time is what you're not supposed to be doing. But that's a good example of reckless use of argument that's designed to create something or result in something that would not be justice. Pay-back time, that would violate your duty and your oath as jurors.

So what are the hurdles in the way of getting to the end of the verdict forms? The Alzheimer's disease. We have talked about it so much I won't sit here and read it to you. It is undisputed that Mrs. Boice had Alzheimer's disease and that it was advanced and that the things that she experienced she was going to experience and nobody could stop it. Nobody. And it is a cause of death. My goodness,

Dr. Locatell says Alzheimer's disease is not a cause of death. Wow. Well, that tells us something about why -- why, um, Ms. Clement uses her for every case that she has -- looked at for the last 15 years.

The weight loss. Um, it wasn't the 20 pounds while Ms. Boice was there, it was -- it was 26 pounds and half pounds over the last six months and it was expected and it was due directly to that loss of the ability to swallow. That can't be blamed on anything or anyone other than the disease. And it was expected. That's why no mandated reporter was shocked by it.

And then the skin breakdown. The SCALE final consensus statement, the one that Dr. Locatell reviewed and didn't accept, that skin breakdown at the end -- the skin breakdown at the end of life is expected, it happens. It can't be prevented. Skin is the largest organ in the body. She didn't agree with that. Um, and it can be unpreventable. These wounds were consistent with skin changes at life's end. They weren't widespread. They were localized to specific portions of the body. She didn't have it on both of sides of her body. She didn't have it on both of her, her -- I'll say it -- butt cheeks. Sure, her elbows, you know. If she was being neglected, like I said, it would be obvious. They weren't infected, um, and, in reality, their presence tells us not that she was neglected but that she lived out her life.

And here's a list of all of the people, the ones at the top specifically told us that they didn't -- that they

expected the skin breakdown. Dr. Awan. Misty Baptista, who use to work for Adult Protective Services, remember? Dr. Fullerton. Mary Ransbury. I think Dr. Tindall ended up saying it because he was being asked in cross-examination. And then you have that whole list of the mandated reporters, the nurses and physical therapist and occupational therapists. All of them saw the skin changes and all of them understood why they were there. And Dr. Locatell is the only person that has testified in this trial that the -- that the skin breakdown constitutes neglect. The only person.

An assisted living community is never going to have medical records. It's never going to have cue shift, every shift charting. It's not going to have documentation of turn and reposition. So how do we know then -- how does it ever defend itself? It defends itself by what isn't there. There was the one fall as opposed to six. Um, there was no fractures. The skin breakdown was localized. All of those pressure points were clear. There is lots of pressure points on the body and -- and, um, Emerald Hills didn't have the benefit of that, um, pressure-relieving mattress that that, um, Foothill Oaks wound up with.

She was at huge risk for aspiration. When somebody can't swallow, that means that they -- they don't control their throat muscles. Aspiration is when your food, your drink, your liquids, even your saliva, go down the wrong pipe in your throat and the substance gets into your lungs and causes pneumonia. She didn't aspirate. That means that

she was receiving very close attentive care. She didn't choke. If you don't have reflexes in your throat, you choke, if you're not careful, if you're not being treated properly. She didn't choke. The -- there were no significant infections, no formal complaints to anyone.

Isn't -- isn't it funny that -- that Ms. Clement and I can say the same thing, but the way we say it has an entirely different meaning? Ms. Baptista, you mean to tell me that nobody complained to you about neglect? No. Well, from -- from Ms. Clement's standpoint: Oh, my gosh, nobody told you she had a wound, how about that? Nobody told you she had a wound on her buttock, did they? No. And that is because she didn't, because she was okay. Yeah, nobody complained. Nobody -- nobody told the nurses. Nobody at Emerald Hills told the nurses, hey, you know, we have got this problem with the buttock wound because it wasn't there.

She was clean. She didn't have hygiene issues. And -- and think about this: They are moving and repositioning her and her skin is fragile. And -- and many of us probably have had that experience of just -- of just grabbing, um, one of our loved one's skin a little too tight and leaving a bruise. We didn't even have any of that. That's gentle handling and attentive care. And then we have all of the evidence of the bedside activities and the interventions by these really awesome people.

So the cause of death, it wasn't -- it's not related to the medication and whether the box was checked or, um, activities, which were being done as much as they could be,

hygiene, training. Her death was a result of her diseases. It -- it -- it can't be disputed. It really can't be. She was in terminal decline, and Exhibit 5019, the death certificate, absolutely establishes that.

So when you get to -- I'm skipping over question 1 for the time being since question 1 is the same for both the wrongful death and the elder abuse verdict forms. I'm just going to talk about question 2 because question 2 on the -- on the wrongful death form is really, really easy. Did Plaintiff prove that the neglect of Joan Boice was a substantial factor in causing her death? No.

And, look, here is one of the -- here is part of the definition of substantial factor: Conduct is not a substantial factor in causing harm if the same harm would have occurred without that conduct. That is key. It can't be a substantial factor if the outcome was going to be the same, and it was. It was. And this is one of the two ways in which the Plaintiffs have allowed you an opportunity to give them an award. It's not up to you to recreate new ways to give them award, even if you want to. It's up to them to present it to you and this you can't do.

Now -- so -- so let's go then to the -- the abuse, um, claim. The abuse claim is very complicated, and there is multiple, multiple hurdles that get in the way for the jury to make an award for the Plaintiffs and it's the only other route they have offered you. The Plaintiffs must prove by clear and convincing evidence that an Emeritus employee failed to meet Joan Boice's needs, that the employee was

reckless, malicious, fraudulent or oppressive in the conduct; that an officer, director or managing agent of Emeritus knew, approved, ratified the conduct with a knowing disregard of Joan Boice's rights -- Joan Boice's rights as an individual -- and that the conduct caused harm to Joan Boice.

That burden of proof that the Plaintiffs have off -- have opted to elect in this cause of action means that they have the burden of proving that -- persuading you that it is highly probable that the fact is true. Highly probable. I guess the opposite of that is likely improbable. I mean, that's a high, high burden, likely probable. You have to be pretty convinced that these things happened.

And let me help you now. Um, there is a -- the first question is, Was she over 65? I think that one is an easy one.

The next question is, Was Joan Boice in Emeritus Corporation's care or custody? That is an interesting one. Um, you know, clearly Kaiser had a big role in this. And I'm not saying they did anything wrong, but I -- I -- certainly we are not turning our back on Joan Boice. She was in our community. And, as a matter of fact, we provided her with a great deal of care through our staff.

But number 3 is when you get to that first hurdle, Did one or more of Emeritus Corporation's employees -- and as we read this I suggest, ladies and gentlemen, that we can substitute the word "employees" with "caregivers Nanette, Lynda, Michelle" -- fail to use that degree of care that a

reasonable person in the same situation -- and I talked about that before. This is a situation unlike that significant majority of situations in assisted living, it's this situation, it's Joan Boice's situation. Failed to use that degree of care -- and it's fail to use, okay. Did they fail? Fail? Not, did they try and fall short?

They failed to use the degree of care that a reasonable person in the same situation would have used in one or more of the following: Assisting in personal hygiene. Did they not assist in personal hygiene? That would have been obvious. It would have been obvious to the Kaiser nurses. Obvious to the physical therapists. Obvious when she got to Foothill Oaks. It would have been obvious. They met her personal hygiene needs.

And you know what, that is another time when it's -- in those questions about, Did you come in and find someone left in a dirty diaper, you know, left in a dirty diaper has a real connotation. Maybe the staff went off and someone had, you know, an episode of incontinence and you come in on shift ten minutes later and they needed a diaper change. The -- the point is that we don't know -- they can't know exactly when a diaper needs changing. What they are obligated to do is be there in time. Don't let harm occur. And that's what they did for Joan Boice.

Hygiene in the provision of food, clothing or shelter. The only one could be food, and the food circumstance is she had food. It was in her mouth. They were giving it to her, she couldn't swallow it.

Providing medical care for her physical and mental health needs. My goodness. I mean, um, working with Kaiser, um, partnering with them, there was a tremendous amount of efforts made to meet her, um, physical and mental health needs.

Protecting her from health and safety hazards. That list I just went through, those were the hazards that she risked and they prevented all of them.

And preventing malnutrition, dehydration. Well, that goes back up to what a reasonable person can do. If someone isn't swallowing well, you are not going to prevent malnutrition and dehydration. It's not what we would call strict liability. It's -- perfection is not the standard here. If -- you know, no assisted living, no long-term care provider could survive if every time someone got malnourished or dehydrated because they couldn't swallow they would be liable. They can only do what's reasonable, and clearly that happened here.

So I submit to you, ladies and gentlemen, that that's the road block right there on the elder abuse form. It's question 3; no. They did what reasonable people would do and could do in Joan Boice's circumstance. And that's the exact same question on the wrongful death form, question 1, which I think should also be no.

Now, if you move ahead, the next question is causation, question 4. And the difference on the elder abuse form is that the causation question is, again, clear and convincing evidence, all right. On the elder abuse

form, even more reason to check the box "no" because of that burden.

But then get to question 5 and it says, Did Joan Boice prove that an officer, director or managing agent of Emeritus -- and I suggest, ladies and gentlemen, when you see the definitions of officer, director or managing agent, the only two people you've been introduced to in this trial that fit that category are Mr. Budgie Amparo and Ms. Melanie Werdel. Um, these are high-level corporate executives that are either appointed by the board of directors or they -- they make policy decisions that are company-wide. And with respect to my friend Lisa Hulse here, she isn't in that position, um, it's Budgie or Melanie. So substitute those names.

Did Joan Boice prove that Budgie Amparo, Melanie Werdel, officer, director or managing agent of Emeritus, engaged in one or more of the following: Had advanced knowledge of the unfitness of the employees who committed the acts and employed them with a conscious disregard of the rights or safety of others? There has not been one ounce of evidence presented by Plaintiffs that, um, these gals that were providing the care, who Plaintiff contends was wonderful -- were great and wonderful and caring, were, quote, unquote, unfit for the job.

B, that Budgie or Melanie, or someone at that level, knew they were unfit, and, C -- and/or C, employed them anyway. I don't care. You know what, this goes to when in a circumstance where -- where an employer is employing

someone with maybe a criminal record and they are -- they are hurting people and the employer becomes aware but they think, okay, it's going to be okay. That's the circumstance that we are talking about. That is not here. So that's no.

2, Authorized, adopted, approved or ratified the wrongful conduct of the employees who committed the acts. Well, what acts? You know, these -- these ladies, according to Plaintiff and according to me, were -- they did the Lord's work. They were wonderful. They were there for Mrs. Boice. And there is no evidence offered, let alone clear and convincing evidence, that, um, Budgie or Melanie -- they didn't know who Joan Boice was until there was a lawsuit. How could they have authorized or ratified it? They were unaware of it.

3, That an officer, director or managing agent of Defendant personally acted with recklessness, oppression, fraud or malice. Again, these folks, Budgie and Melanie, they had no involvement with Joan Boice's care at all. And they -- you know, the care was being delivered by the people at Emerald Hills, these wonderful people at Emerald Hills, and Budgie and Melanie were not part of that care team. The answer to question 5 is also no. That is a road block.

And now -- then question 6 is, Did Budgie or Melanie act with, um, recklessness, malice, oppression or fraud, in -- in relation to this -- where it gets really, really complicated -- in relation to all of the prior questions. The failure to, you know -- we go back to the question 3 -- you know, providing food, shelter, clothing. It's just not

there. It's not there.

And then question 8 takes out the word "reckless" and it only focuses on malice, oppression or fraud. And I want to talk about those concepts for a second.

But, first, I told you I wanted to talk about labels. Personally, I think labels are one of the greatest threats we have to fairness. I heard this quote and it was amazing to me. Once you label me, you dismiss me. Kierkegaard. I don't even know who he is. A philosopher I guess. But what an amazing quote.

I'm Bryan Reid. I'm a parent. I'm a husband. I'm a son. I'm a lawyer. I'm a defense lawyer. I'm Emeritus' lawyer. You see what a label does. It doesn't change that I'm Bryan Reid. And -- and that's what is in trial. We have the "head nurse", the "head of sales", the "boat salesman". My goodness. You know what Ms. Ruether said about the boat salesman, He was a great guy. Look what that does to this poor guy. You call him a boat salesman and immediately everyone dismisses him. Is somebody that has sold boats in his life not capable of being a wonderful, caring administrator, business operator? My goodness. That goes in the NA column. That goes to bias and prejudice. Don't fall prey to labels.

"Kool-aid drinkers" I heard this morning as a label. "Regional director of cover-up." You think that is what Doris Marshall thought she was with all of those years she was working for Emeritus? I don't know for sure, I haven't looked at the -- I don't even think she agreed with that.

But my goodness, come on, you just -- you dismiss these people when you label them like that. That's not how we get to justice or fairness. Let's be respectful of people, of -- of -- of -- of humans and recognize that we are complex beings with our lives and our -- and our -- our challenges and our motivations and our desires.

"Corporate." Now, there is a label for you. What does that put in your mind? Well, there has been eight weeks of trial that's tried to connect something to that word. All that is is a word and it's nothing else. And Emeritus has now become a label. Emeritus is a piece of paper. I told you that in opening statement. That label represents tens of thousands of employees. These are people who have dedicated their professionals lives to taking care of elderly folks at every level of the organization. When -- so -- so instead of Emeritus the label, think of Emeritus as a football stadium filled with people.

They go to work -- I added this during the closing argument -- with a purpose of serving the people that Ms. Clement, um, you know, talks about that -- that -- that, you know, should be advocated for. That's what they do. And they are mothers and fathers and sons and daughters and cousins and aunts and uncles and scout leaders and, you know, rotarians. They are people, too. And they get labeled for the sole purpose of accomplishing the Plaintiffs' goal. They are not perfect, but, thank goodness, none of us are and none of us are required to be. They are not abusers and they aren't evil.

One of the -- one of the questions before you you might get to is fraud. Now, fraud is defined very, very, very specifically, um, and Ms. Clement just blew right through it, okay. Fraud isn't just a statement. That is not true. Fraud is an intentional misrepresentation of a material fact with the intent of depriving Joan Boice of a property or a legal right, um, which caused Joan Boice injury. So it's not about a statement out in the universe that isn't -- isn't accurate. It's about this intentional misrepresentation that was made to Joan Boice for her to rely on and it wasn't intended to be true. That's important.

There is no evidence that anything that was said or delivered or presented was not intended to be true. As a matter of fact, it was all intended to be true. The best Plaintiffs can do is say they weren't executing it well. But nobody intended -- there is no evidence anybody intended to not deliver and, in fact, I suggest they did deliver.

Recklessness. That conduct is highly probable, it's a knowing disregard. So that means that this reckless standard, that means that Nanette and Lynda and Alicia saw Mrs. Boice sitting at the table with the food in front of her, said she can't feed herself, too bad, she is on her own. Conscious disregard. There is no evidence of that. The evidence is opposite, they worked extremely hard to meet her needs. And it's way beyond just failure to use reasonable care.

Malice, oppression, despicable conduct. These are

incredibly powerful words. And if you -- if you get to those words in your deliberations, which I don't think you will, but if you do, I suggest, ladies and gentlemen, that it's time to -- it's time to take a breath. It's time out, okay. We have been in trial for two months. We have been talking about Emeritus for two months. Our world has been condensed down to this case. We need -- we need to step back and understand what malice, what vile conduct is, what's despicable. It doesn't change in a courtroom. There -- it's the same concept. And we know what evil is. That's what we are talking about, we are talking about evil. And, you know, you don't have to walk very far out of the courtroom to -- to re-familiarize yourself with these notions.

I walked out of my room this morning and on the floor was the Sacramento Bee. Father held in hatchet slaying of 9 year old, okay. That's despicable conduct. That's malice. That's evil. That's what we are talking about. It doesn't get redefined, you know, in this courtroom. There is another trial going on I heard where three men murdered a cab driver over 40 dollars. Are you willing to -- to compare this football field of moms and dads to that? Those are the standards. That's what you're being asked to determine and it's not there.

I'm going to put all of these up here and finish my comments. The right to a fair jury trial is set forth in the Seventh Amendment of the Bill of Rights. The right to a civil jury trial was as important to the founding fathers as

the right to free speech, the right to freedom of religion, the right to bear arms, all of those rights. Seventh Amendment, right to a civil jury trial.

And so as I ask you to step out of the courtroom in this process, I ask you to think about the import of you putting your hand up in the air and taking that oath. When you did that, you became a part of the history of justice. You became part of the fabric of justice. You became -- you became kin with hundreds of years of jurors all dedicated to trying to do justice and that means following the law.

And even if some of you are sitting there thinking, my goodness, I'm not particularly happy with Emeritus and I think, you know -- I feel bad for these people, in the grand scheme of things, doing your duty as a juror is far more important than trying to feel good about a decision. And I suggest, ladies and gentlemen, that doing your duty as a juror should feel good. It's a decision you can live with for every day you get up and you look in the mirror, you can live with that decision because you did the right thing. I asked you at the beginning, is the right thing always the easy thing? No. Is it easy to send these folks away with nothing? No. Is it the right thing? There is too many hurdles. They have presented -- they said this is -- this is -- what we want you to do and you can't do it.

You know, I -- I -- I -- a week ago I attended a seminar about Lincoln, the lawyer. And Abraham Lincoln was an amazingly accomplished trial lawyer. He tried thousands of cases way back to juries and I think, I wonder what a

trial like this would look like if Abraham Lincoln represented a party. I wonder if people would be belittled and mocked and -- and assaulted. I don't think so. Why? Because that's not how we get to truth.

When -- when we need to get an answer and we want the truthful answer -- think about this: Those of us with kids, and I have two, I come home and there is a lamp broken or a cookie jar is empty, if I go to my son and say, I know you ate the cookies, if you lie to me, it's going to be twice as bad so just tell me you ate the cookies and you'll get your punishment and we will move on, but don't lie to me because I know you did it, what's he going to say? Probably he is going to say he ate the cookies, even if my daughter ate them.

The way you get to truth and justice is to say, I notice the cookies are missing, what happened? Let's talk about it. Let's inquire. Let's -- let's talk to both the -- both of the kids and see, you know, which of these -- we are going to get to the truth. We are going to know who ate the cookies or the cupcakes -- was it a cupcake?

UNIDENTIFIED JUROR: Cake.

MR. REID: Chocolate cake. We will get there. And it will be just and it will be fair and it will be right. But let's not bully people into confessions and then say that's justice. It isn't and it doesn't comply.

You need to be true to your oath, ladies and gentlemen. And I -- I -- I -- you know, I want you to think about as you go back into the deliberation room, in reality

with that Seventh Amendment and the California -- the Judge read to you it's a fundamental right in California to a fair jury trial, when you're back there and you're deliberating, think about those founding fathers over your shoulder and guiding you. Are you doing the right thing? Are you making the right decisions for the right reasons? And -- because they are going to be there. And -- and in the grand scheme of things, you're -- you're serving them. You're serving history. You're serving justice. You're serving the system. That is what this is about. It's really not about Emeritus or the Boice family, it's about this process.

And yesterday -- I'm just going to share this with you: I struggle with it, but yesterday -- there is a beautiful cathedral here in Sacramento and I walked down there. I'm not -- I have kind of a complicated religious, um, background, but I'm spiritual. And I -- and I went down there yesterday and, um, listened to the priest and he read the -- the scripture and he said -- and then he did his homily as a sermon and he said, Now, did you hear what Jesus said? Were you listening? And the reality was I wasn't, you know, I was thinking about today.

He goes, I hope you were listening because that is what this scripture was about, they weren't listening. The people that were with Jesus, they weren't listening to him, and he was telling them what was going to happen him. And he really kind of teased us about that for a while until he finally told us what he said. And it was just what stuck with me was this message, listen. Whatever your -- your

connection is, whatever your guidance is, whatever your faith is, listen for that guidance. It will be there and it will help you do the right thing.

My clients and I, we are here for justice. We really are. We are not -- we want a true just outcome. I think the outcome will favor my client. But it has to be fair and it has to be just. And I'm going to sit down and Ms. Clement is going to address you again. And I don't know what she is going to say. I think she is going to ask you for an extraordinary amount of money, a huge transfer of wealth. She is going to go back to the themes that we have heard for eight weeks. That closing argument wasn't anything different than what we have heard for weeks, and we are going to hear it some more.

And as it's being delivered, please, rather than fall prey to the pulls on emotion, I ask you to have your antenna and when somebody is playing to your emotions, the antenna goes up. And rather than falling for it and being party to it, say, why is this happening? I'm not supposed to do it. I'm supposed to do my job as a juror. I'm supposed to follow my oath and follow the law. Why are my emotions being tugged and pulled at? Why am I being told about things that has nothing to do with Joan Boice?

I know you're going to do a terrific job. Please listen. Please consider who is in that room with you as you deliberate and be true to your oath. Thank you.

THE COURT: Ms. Clement.

MS. CLEMENT: Yes.

I guess I'm a bully. A real bad actor. I guess you guys have seen that all through the case, huh? Just attacking witnesses, you saw that in all of the videotapes. You saw that in everything, that I just kept attacking, attacking, attacking people, right? You saw the videotaped testimony of the witnesses. You saw what they have had to say. I don't think Alicia Parga was crying in her deposition, nor was Peggie Stevenson or Nancy Cordova.

Mr. Reid started out by saying that they were sorry for the loss. That's the first time Emeritus ever said they were sorry, ever. They are not saying it now. They are not sorry for a single thing. Look what people were doing, saying, let's look at their actions. Let's look at what they documented. Let's look at how they directed their people, what they told them to do, how they pressured them.

Emeritus didn't live Joan Boice's pain or her children's pain at their loss of losing their mother. Lots of debilitating illnesses Joan had. Hum. She really didn't, did she? She didn't have diabetes. She didn't have peripheral vascular disease or peripheral arterial disease or coronary artery disease or congestive heart failure. She didn't have cancer.

She did have dementia. She did have some arthritis in her spine. She did have some high blood pressure at times. She did have a compression fracture in her back which had healed. She did have some urge incontinence that Dr. Locatell described for you, and she did have some impaired vision. She was exactly the kind of person that

Emeritus is paid a lot of money to care for. It's a residential care facility for the elderly, not a hotel.

And, um, they did blame the family, didn't they? That's what they do when they are caught. Why didn't they move her? Why didn't they move her? Why didn't Susan Ruether move her mom too? Why didn't they move her right away? Why didn't they move her?

You know, um, last weekend I watched Steven -- Steve Jobs, the guy who started Apple, recently passed away -- and Pixar, I watched his commencement speech to Stanford of 2005. And, um, one of the things he said was, We can't connect the dots moving forward, we can only connect the dots looking backward. The family wasn't connecting all of the dots. Nobody was telling them everything that was going on at the facility. And she wasn't there very long. There is no evidence that she could have gone back to The Palms after they gave their 30-day notice.

They never -- the family never took their complaints outside of the building? Well, we are here. This is their complaint, and they are coming to the people who can do the most about it. Dr. Martin, he said, no inquiries at all Emeritus says to Dr. Martin about Joan Boice. Really? Don't you remember Kathleen Boice on the stand trying to tell you about what she was told about Joan's condition, what she was told by the nurse on the admission who was looking at her skin and there was an objection from Emeritus? They didn't want to hear -- they didn't want you to hear what they knew had been told to the family about

Joan's condition. That was hearsay, and they didn't want you to hear that.

Eric Boice, police officer for nearly two decades, Kathleen Boice, very sharp, no call to Adult Protective Services. Excuse me. No call to the Department of Social Services. Excuse me. An immediate difference in the quality of care if the ombudsman had called or Department of Social Services. Really? What evidence did we see of that in this case? One hundred sixty-five unusual incident reports to the Department of Social Services and no change. Kathleen Boice told you what her experience has been working with an even higher regulatory agency, the medical board.

Here is a formula: Return focus to the Plaintiff, return focus to the Plaintiff, return focus to Kathleen, to Erik, to Mark, to Nancee, to Joan, to Myron. Blame it on the guy who can't even talk here today for you, her husband. Complain about Joan. Blame it on her. You know what my grandma told me, when you point the finger at someone, you got three fingers pointing back at you.

Melissa Gratiot was part of my team. Really? Really? They didn't know it was in the works. They didn't know that the family was concerned. They didn't know that? Really? I think we saw and heard a lot of evidence about that. Family begged for a meeting and it took them two weeks to get one. The family came with an agenda and they sat down and they talked with Peggie and Nancy and Melissa. And what was the response? Gosh, we are really sorry. We are going to get right on that. We are going to take care of that.

We are right there with you.

And the family felt good because the family did not want to uproot Joan again and move her and separate her from Myron. They didn't want to do that. They wanted to stay together and they thought they could make this work. We are a team now they thought. Okay, they have heard us. Maybe it's not going to happen overnight, but they are going to be on it. But did they know and was there disclosure at that time of any material facts that might have made a difference to the family like, hey, last night there was nobody in the Memory Care Unit overnight to take care of your mom?

Emeritus knew it had been in works for a long time because in December the family requested -- December of '08 the family requested her records, and instead of just photocopying them and giving them to the family, they had to send them up to corporate. And it took six weeks for them to give them back. Willful suppression of evidence, destruction of evidence. That is your instruction. It's one of your instructions. I think it's 204, willful suppression and destruction of evidence. Consider that when you consider about what Emeritus' conduct has been in this case about Joan Boice.

Pressure to move in. Pressure to keep high acuity residents. This is what the witnesses testified to and it didn't seem to me that I was badgering them. I don't recall the Court, her Honor, admonishing me that I was inappropriate or badgering witnesses. In fact, I don't recall any of those witnesses being instructed by the Court

that their responses were non-responsive or they were arguing. I don't recall that happening with the witnesses that we put on the stand, unless we were calling them adverse witnesses. Lisa Hulse, Mr. Amparo, all of the Defense experts, every single one of them argued and were instructed by the Court that their answers would be stricken for being non-responsive. The evidence has been in this case from Nancy Cordova, who volunteered it in her deposition, that she was pressured to move residents in and to keep high acuity residents.

Insulin injections. Why was that important in this case? Gosh, I don't know. Maybe it would give you an idea about what was going on in that building when Joan was there. What were those employees, those poor employees expected to do? What kind of patients were they bringing in? It wasn't just about Joan. There were a lot of other people who were being mistreated in there and that's a corporate culture.

"Close the back door" played no role, it played no role in this case. Really? When Joan had a stage 3 pressure ulcer, restricted condition, when Joan was bedridden and other people in that building were bedridden and they didn't increase the staff and they didn't immediately seek to transfer her out of the facility or tell the family, that played no role?

Our case took six weeks to try. That's true. I guess Emeritus forgot about all of the time they spent asking questions over that six weeks, huh?

The VPQS reports, Exhibit 207, what are they tracking? Well, in case anybody forgot what they were tracking, let's see. The risk of media exposure. The risk of residents requesting their own records. The risk of regulatory exposure. The risk of residents moving out. What do any of those things have to do with nursing?

The majority of the people that we called knew nothing about Joan Boice. Really? A lot of those people knew about the culture at Emeritus and what was happening while Joan was there and what happened leading up to the time that put Emeritus Corporate on notice, on notice. That's one of the things we have to decide, did they have advanced notice? Did they know? Did they adopt, approve, or ratify conduct? You bet they did.

And who didn't know about Joan who worked at the facility? Peggie. Peggie Stevenson, who we watched her video testimony. Did she look badgered in her video testimony -- Erik, do you have that clip ready to play -- when she came back her second day and wanted to tell me about what we talked about off the record?

(The following video excerpt was then played in open court:)

Q I want to start off this morning with where we ended off last night, and in particular, with a conversation you and I had after the deposition. We had to end early because Mr. Prout had to leave, and you and I had a discussion on the topics that we were discussing right at the end of the deposition, which was related to your complaints and concerns about your job and the job of the Memory Care Unit

director, and some of the other staff.

So starting with that, I would like to talk to you about the concerns that you had as an RN and the resident care coordinator at Emeritus Emerald Hills with the med techs passing psychotropic drugs on a PRN basis.

A My concern as a licensed individual was that, um, the State was allowing assisted living centers to have unlicensed individuals who are trained for a minimal amount of time assisting patients with medications. Uniquely, in the Memory Care Unit, because the patients there I did not believe were able to make -- to have made consent to take medications, and, therefore, it was a fuzzy cross-over from assisting to administering. And that was one of the reasons that I left Emeritus and assisted living in general, because of that particular policy.

Q So was it your experience at Emeritus Emerald Hills in the Memory Care Unit that the med techs were actually administering the medication as opposed to assisting the resident with taking the medication as a result of the dementia that those residents suffered from?

A It would depend on the particular resident in question. Some had more capacity than others.

MS. CLEMENT: That is enough, Erik.

(Video stopped.)

MS. CLEMENT: Badgering.

Food. Maritza Morales, what did she testify to? The refrigerators were locked at night. Food. What was the corporation doing about food for the residents? What was it

Mr. Finden told us? 4 dollars, 4 dollars a day. What was it they told us in their interrogatory answers that were read and admitted into evidence? Somewhere between 3 and a half and 4 dollars a day.

Joan Boice and her family are not here for sympathy. They are here for justice. They are here to expose the lie. And the Court ruled on what is relevant in this case and what evidence comes in and how the attorneys can ask questions, not me. The Court decided, her Honor decided what was relevant and what was admissible and what came into evidence based on the law.

Did you see any evidence of the caregivers, the witnesses, being attacked?

It's a vulnerable corporation. Really?

(Discussions were had between attorneys.)

MS. CLEMENT: Mrs. Hulse was no match for me. Mrs. Hulse was just asked questions and at times she chose to lie.

Where is the evidence of training and support? The policies. The Court read you the instructions on policies and what are policies and who a managing agent is and who can make policies and what those policies are. Formal policies are written or unwritten policies. Written or unwritten policies. And we sure heard a lot of evidence about what the true policies were. Where was the evidence of training and support for the staff on learning what the Emeritus policies were? All of the evidence we heard about was training for the directors on sales and marketing. That

was their training.

And you know what, high-five Emeritus, you make money. Great. Good for you. That is fine with me. But you need to take care of the people you serve first.

The burden of proof for us is high. That is why we put on a lot of evidence. It was convincing evidence I say. Convincing evidence. And I don't think we needed to have one or two or three or four or five experts come in here to testify to how many staff we needed. We had the evidence of the staff from their own employees. You needed at least three people in that Memory Care Unit on every shift. Anna De La Cerda, corporate, you needed to have at least one person on every shift for each floor of the building.

I mean, is that rocket science when the evidence was that 70 percent of the people in the Memory Care Unit were at the highest level of care? That would be evidence that the Defense introduced through Mr. Finden, and the evidence that came in through Doris Marshall, Exhibit 264, that increasing the level of care, the big dashboard chart, that they were required to increase it every quarter by another 25 percent. And Mr. Finden's evidence that he produced during the budget and the actual numbers was to how much money they were collecting for increased levels of care throughout that building. It wasn't all independent people driving to the bank.

Consider the demeanor of the witnesses. Compare the demeanor of Dr. Locatell to nurse Ransbury, Dr. Tindall, and Dr. Fullerton.

Erik, can you put that up? Thank you.

Expert witness testimony. You do not have to accept an expert's opinion. As with any other witness, it is up to you to decide whether you believe the expert's testimony and choose to use it as a basis of your opinion. You may believe all, part, or none of an expert's testimony.

Thank you, Terrance.

COURT ATTENDANT: You're welcome.

MS. CLEMENT: The Defense experts all contradicted each other. And to say that there was nobody who opposed Ransbury and Tindall, well, that's just not true because Dr. Locatell opposed them in her testimony. We didn't have to go out and hire three people from far away to come in and tell you what is very obvious in this case, that Joan Boice was neglected. Excuse me. Those experts flip-flopped in front of your eyes, didn't they? They just flip-flopped like this (indicating.) They argued. They refused to answer questions.

And how was Dr. Locatell's demeanor? Straightforward. Answered questions straightforward. There is no evidence in this case that Dr. Locatell only answers to me. That is, frankly, outrageous and disrespectful.

And this poor vulnerable corporation. What did we learn about this poor vulnerable corporation through Doris Marshall? That this is the sixth law firm that Emeritus has chosen over these four years.

Those experts contradicted each other. Nurse Ransbury, she testified that Joan Boice could not

independently transfer out of her bed, that she was technically bedridden. Contradicted by the other experts the Defense called. Nurse Ransbury testified that on November 4th that metatarsal head right foot pressure ulcer, that wasn't healing, contradicting each other. And she testified, after denying it, we had to play her videotape, that in her opinion the Kaiser home health care staff inappropriately staged Joan Boice as having multiple pressure ulcers.

And let's look at what Dr. Fullerton testified to.

MR. REID: Your Honor, I -- could we approach?

Are we going to see a video?

MS. CLEMENT: No.

MR. REID: Oh. I apologize.

MS. CLEMENT: We do need the lights though.

Go ahead, Erik.

He told us that Emeritus promises the State of California that it will comply with the regulations in order to get a license to operate accordingly with the State. He told us that. And then he told us that it's not really a standard of care, that it's not really required, and that as of November 4th, um -- once they got to November 4th or 5th when home care got involved, then they didn't really have to follow the regulations. And then he told us on direct examination by Defense Counsel, who -- well, it is true, he did lead him through every single question. But I wasn't leading Dr. Locatell and that was pretty obvious. She had her own opinions and she voiced them clearly.

On direct he was saying, Oh, if she had been neglected, you would have seen all of these other things. She would have had infections. Oh, yeah, she would have had infections. She would have had, um, lots of other problems.

But the right ischial pressure ulcer was infected, true? Oh, yeah, that's true. And when she got to Foothill Oaks, she had another infection, she had a urinary tract infection where her urine was foul smelling and cloudy and they had to put her on antibiotics? Yeah. And to a reasonable degree of medical probability those urinary tract infections was from bugs that grew out of her urinalysis, that was from sitting in a dirty diaper.

And then he told us about how severe this pressure ulcer was on her bottom. And I just want at this point to correct something Defense Counsel stated about how -- that there wouldn't have been -- you know, this whole concept that she didn't have ulcers on both sides of her body. She had ulcers, and we went over those on the December 4th admission to Foothill Oaks with Dr. Fullerton and also with nurse Ransbury, she had pressure ulcers on both bottoms, both sides of her bottom. One more severe than the other. She had it on both hips. She had sheering from the -- from her diaper being pulled up too hard through the middle of her legs. She had pressure ulcers on both feet.

And here he talks about that Joan had this fistula from a tunneling of the pressure ulcer that was actually going in where the feces would have been coming through and it would normally excrete through her anus and rectum but it

was coming into the wound itself. And Defense Counsel and Emeritus want to tell you that Joan Boice didn't experience any pain.

And this is what he said on direct: There was nothing Emerald Hills could have done to alter this outcome. No. This is how she was going to die. This is how they die when they die. But when he was challenged about these spontaneous bed sores, he had to admit that, um, wow, they all started healing when she got out of Emeritus after he had already testified that there was no way to cure them, there was no way to stop them and that they weren't healing. Then when I had to point it out to him, he flip-flopped and said, Oh, yes, yeah, that's true. And I think he even said, um, They got lucky.

And he talked about too that Kaiser and the home health are not the licensee of Emeritus and they are not obligated to make sure Emeritus is complying with its own laws. And he also agreed that Kaiser was in that building at Emeritus Emerald Hills for about 1 percent of the time, from the time the first bed sore was told -- brought to the attention of the family and Dr. Awan by the family on November 4th.

And Dr. Tindall, why would I have asked him all of these other questions at trial? Don't you remember, it was all what he talked about in his deposition. See, in his deposition he was conflicting the other experts, but then the Defense did not want that to be disclosed at trial so they stayed away from that.

And Dr. Fullerton testified to a reasonable degree of medical certainty Joan Boice didn't have a stroke on September 22nd, and Tindall disagreed with that. Of course, Dr. Tindall also disagreed with the EMTs, the Sutter nurse, the Sutter doctor, and Dr. Awan.

THE COURT: Ms. Clement, I apologize. I want to get some sense of timing to decide how we are going to proceed now.

Could you and Mr. Reid please come up to the sidebar?

MS. CLEMENT: Yes.

(Sidebar conference was held.)

THE COURT: Ladies and gentlemen, despite our diligent efforts, it looks like we won't be done by 5:00, and so I don't really want to keep you later now because I know it's been a very long day. Therefore, I'm going to order you all back -- we will be done tomorrow morning. I will order you back at ten o'clock tomorrow morning because I have a hearing in another matter at 9:00 a.m.

So if you will please leave your notebooks on the chairs. Remember the admonitions. I will see you at 10:00 a.m. tomorrow.

(The following proceedings were held in open court, outside the presence of the jury:)

THE COURT: All right. We are in recess until 10:00 a.m. tomorrow morning.

MR. REID: Is it okay if I turn it over to my --

THE COURT: Yes. I know you will not be here tomorrow.

MR. REID: Thank you.

THE COURT: All right. Thank you.

We are in recess.

MS. CLEMENT: Thank you, Judge.

(Evening recess.)

(Case continued to 3/1/13.)

---oOo---